FAMILY COURT OF AUSTRALIA

RE: JAMIE (SPECIAL MEDICAL PROCEDURE) ***[2011] FamCA 248***

FAMILY LAW – CHILDREN – special medical procedures – gender identity dysphoria

Gillick v West Norfolk A.H.A [1986] AC 112
Re Alex: Hormonal Treatment for Gender Identity Dysphoria(2004) FLC 93-175
Re Brodie [2008] FamCA 334
Re Marion (No.2) (1994) FLC92-448
Secretary, Department of Health and Community Services the JWB and SMB (1992) FLC 92-293 (*Marion's case*)

APPLICANTS: The Mother and the Father

INDEPENDENT CHILDREN'S LAWYER

FILE NUMBER: By Court Order, file number is suppressed

DATE DELIVERED: 6 April 2011

JUDGMENT OF: Dessau J

HEARING DATE: 28 March 2011

REPRESENTATION

By Court order the names of counsel and solicitors have been suppressed

ORDERS MADE 28 MARCH 2011

1. That Mr and Mrs S shall be authorised to consent to treatment on behalf of their child Jamie under the guidance of Jamie's treating medical practitioners including but not limited to his endocrinologist Dr G and his psychiatrist Dr C, for the administration of Zoladex (a GnRH agonist) and cyproterone acetate 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.
2. That the full name of Jamie, Jamie's family members and their occupations, the hospital, the Independent Children's Lawyer, Jamie's medical practitioners, Jamie's school, this Court's file number, the name of the Family Report writer, the State of Australia in which the proceedings were initiated, the name of the parents' lawyers, and any other fact or matter that may identify Jamie shall not be published in any way, and only anonymised Reasons for Judgment and Orders (with cover-sheets excluding the registry, file number, and lawyers' names and details, as well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, for provision to the treating medical practitioners and to enable their execution, and one cover-sheet of Reasons for Judgment that includes the file number 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 adjourned for Reasons for Judgment and further orders on a date to be advised to the parties.

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

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order, file number is suppressed

The Mother and the Father
Applicants

Independent Children's Lawyer

REASONS FOR JUDGMENT

INTRODUCTION

1. "Jamie" and his non-identical twin brother were born in May 2000. They are now 10 years' 10 months. They are the only children of Mr and Mrs S, the applicants.
2. The children are in Grade 5 at school where, since mid-2009, Jamie has been known exclusively as a girl, wearing girls' clothing, being addressed as a girl by classmates and teachers, using the girls' toilets, sleeping in the girls' dormitory at camp, and generally presenting as a very attractive young girl with long blonde hair.
3. As the family and all the relevant medical experts refer to Jamie using the female pronoun, I shall also do so for the purpose of these Reasons for Judgment.
4. Medical experts diagnose Jamie with gender identity disorder. They support the parents' application for Jamie to undertake the following special medical procedures:

    (a) The administration of puberty suppressant hormones, such as implants of Zoladex (a GnRH agonist) at intervals and at a dosage as may be determined as necessary to achieve suppression of Gonadotrophins and testosterone to pre-pubertal levels under the guidance of Jamie's treating medical practitioners including but not limited to Dr G, (Endocrinologist) and Dr C (Psychiatrist);
    (b) Additional treatment of oestrogen as may be considered appropriate by Jamie's treating endocrinologist, currently being Dr G (Endocrinologist) and in consultation with and on the written advice of Jamie's treating Psychiatrist, currently Dr C (Psychiatrist).

5. The medical practitioners were unequivocal as to the absolute urgency for Jamie to start what is referred to as "stage one" treatment, to suppress male puberty.

She currently has the pubescent development of a 14-year-old male, and it is rapidly progressing. The concern was that physiological developments, such as a deepening voice, would be irreversible unless treatment was started. For that reason, the hearing in this case was brought forward.

6. On 17 January 2011, I made an order inviting the Office of The Public Advocate and the Department of Human Services to intervene in the proceedings, particularly in view of Jamie's young age. Both declined. I have however been greatly assisted by the Independent Children's Lawyer, who arranged an urgent Family Report to facilitate the early hearing, prepared useful written questions to the experts before the hearing, and also performed a helpful role in cross-examining the witnesses, and in making submissions.

7. The Family Report writer and the ICL were supportive of the stage one treatment starting immediately, as sought by Jamie, her parents and doctors. I agreed. On 28 March 2011, at the end of the hearing, I made an order to permit that.

8. These are the reasons for that decision, and for the decision that I reserved in relation to stage two of treatment.

9. The applicant parents, supported by the medical practitioners, argued that both stages of treatment should be viewed as the one treatment program and approved now, without the expense for the parents, and the uncertainty for Jamie, that a return to court is likely to entail.

10. The ICL, supported by the Family Report writer's evidence, argued that treatment not yet due for some five to six years should be considered by the court closer to that time, to take into account prevailing or intervening circumstances that may not be predicted when the child is at this stage still only ten.

BACKGROUND

11. Mrs S is aged 43. Mr S is 49. Both work. They have lived together since 1995, and been married since 1999.

12. They said that Jamie first began identifying with the female gender when she was about 2½ to 3½ years' old. She chose female orientated toys, began to identify with female characters on television or in movies, and told her mother: "Mummy, I don't want a willy. I want a vagina."

13. Mrs S swore that she and her husband tried to reinforce Jamie's masculinity, encouraging her to wear male clothing, have her hair cut short, and play with gender-neutral toys. She said that despite that, Jamie became "more insistent on identification with the female gender." She said Jamie would ask questions such as "When is my fairy godmother going to turn me into a girl", and at home in the pre-school years she dressed up as a girl, asked to go to ballet classes, and was disappointed that she was not able to wear a tutu or a girls' costume in the ballet concerts.

14. The twins started kindergarten in 2005. The teachers told Mr and Mrs S that Jamie was always dressing up as a girl in the dress-up corner. She mainly sought the friendship of girls. Mrs S said that at about that time Jamie started saying to her parents "Don't let me grow a beard". She insisted on wearing "girlie" clothing.

15. The parents said that when the children started school in 2006, Jamie's insistence that she was female increased significantly. They said that "gender" was her primary topic of conversation and that she spoke about it constantly. She found it difficult to settle at school. She was teased. She had longer hair than most boys. She had her hair cut short but immediately regretted it. She would not use the boys' toilet at school. She would try to hold on all day, leading to many "accidents" whereby she wet herself. She was often distracted at school, and moody and sad at home. She had episodes of sobbing and angry outbursts, and sometimes she said she hated herself and wished she were dead. She stopped going to dancing classes and said she would not dance again until she could be a girl. Her mother said that Jamie told her:

> Mummy, it is so hard trying to be a boy" and "I go to school disguised as a boy.

16. Mrs S said that she and her husband continued to encourage Jamie's "maleness".

17. She described a "turning point" in July 2007 when Mr S was taking Jamie to the opening of "Phantom of the Opera". According to the mother, Jamie was so distressed about what she would wear, saying that she should be going in "a ball gown". To alleviate her distress, Mrs S put together a girl's outfit for her and promised her that they would get help for her and would buy her female clothes to wear. At that point, Mrs S contacted the Gender Dysphoria Clinic and obtained the name of Dr C, a psychiatrist experienced in this area. In the meantime, Mrs S bought girls' clothes for Jamie, which she began wearing at home.

18. They first saw Dr C in about October 2007, when Jamie was seven. Mrs S said they attended weekly appointments for two months and in December 2007, Dr C diagnosed Jamie with gender identity disorder. She said that she and her husband were "relieved" to know there was an explanation for their child's insistence that she was a girl.

19. According to Mrs S, Jamie became much happier after her appointments with Dr C. She described herself as "half boy, half girl". When Mrs S asked her which part was a boy, Jamie would say "Just my willy…the rest of me is a girl". She had initially hoped that Dr C would simply give her a tablet that would give her a vagina, and was disappointed to find out that was not what would happen. Mrs S said that she continued to ask a lot of questions about becoming a girl.

20. During 2008 (when Jamie was seven or eight years old) she began to wear more female clothing at home. She began growing her hair, wearing pony tails, and bootleg pants. Some of her friends knew that she lived as a girl at home. She was often asked at school if she was a boy or a girl. Mrs S said she was upset by these questions.

21. Towards the end of 2008, Jamie's twin brother, who has always supported Jamie, was firm in announcing "I have a sister", and the family then started addressing Jamie as a girl.

22. In late 2008, Mrs S notified the children's school of Jamie's diagnosis of gender identity disorder. At the start of the 2009 school year, when the children were starting Grade 3, Mrs S notified Jamie's teacher that they were using the female pronoun for Jamie at home, and requested that the same should occur at school. She said that although the school tried to accommodate Jamie's diagnosis, the Principal still insisted that Jamie must use the boys' toilets. There were also issues around where she would change, for example for the school swimming sports.

23. Unhappy with the school, the parents changed both children to their current school at the start of Term 3 in 2009. Jamie is known exclusively as a girl at this school. The children both love the school. Jamie has started dancing again. She attends tap dancing classes and is particularly interested in singing, writing music, and playing the guitar. With two girlfriends from her old school, Jamie is the lead singer in a band called the "…".

24. Mrs S described Jamie's brother as very accepting of Jamie's identity as a female. She also described close friends and extended family as loving and supportive.

25. She is concerned that Jamie has entered puberty, and reported her as very worried about her voice breaking, an Adam's apple growing, and the prospect of facial hair. She said that Jamie has had a heightened sense of anxiety about her future since entering puberty.

26. Mrs S set out a sound understanding of the proposed treatment. She said that when Jamie is an adult she can decide for herself whether she wants to undergo surgery to remove her testes and penis, and to create a "neo-vagina". She said they have at all times reassured Jamie that she can change her mind, and they have consistently told her that she will have their support no matter what gender she identifies with.

27. At paragraph 48 of her affidavit, Mrs S set out her concerns if Jamie could not receive the stage one treatment, as follows:

> If [Jamie] does not received [sic] the phase 1 treatment, she will very shortly develop obvious male characteristics such as deepening of her voice, facial hair and other more masculine features which will be permanent and will not be able to be

> reversed. At the moment [Jamie] can live comfortably as a girl, is socially confident and suffers no teasing or social isolation. If male features become obvious, I fear that [Jamie] will not easily be able to live as female. I believe that she will continue to identify as a female, but it will be harder for her to maintain that public identity. In the past [Jamie] suffered immensely when she was asserting her female identity by being constantly reminded of her biological male gender at school and in public. At that time she was obsessed about her gender, to the exclusion of all other interests and her education. I am concerned that if [Jamie] is again placed in a position where her biological gender is publicly revealed or even questioned, she will regress emotionally, psychologically and academically. I am very concerned by Dr [C's] opinion that [Jamie] is likely to develop depression and will be at risk of self harm.

28. Mrs S also swore that although she has been advised by the relevant doctors that Jamie will be the youngest patient they have commenced treatment with, she is confident in and accepts their advice that the treatment is appropriate for Jamie's age, and most particularly her stage of development.

MATERIAL RELIED UPON

29. The applicant parents relied upon:

    a. Their Initiating Application filed 10 January 2011

    b. The mother's affidavit filed 10 January 2011

    c. The father's affidavit filed 10 January 2011

    d. The affidavits of the endocrinologist Dr G filed 10 January 2011 and 9 March 2011, and letter dated 21 March 2011

    e. The affidavit of the treating psychiatrist Associate Dr C sworn 23 December 2010 filed 10 January 2011, and letter dated 24 March 2011

    f. The affidavit of the psychiatrist who gave a second opinion, Professor N, filed 4 February 2011.

30. There is also the Family Report prepared by Dr MW dated 25 March 2011.

RELEVANT LEGAL PRINCIPLES

31. 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.

32. 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).

33. 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*)). There was no dispute in this case that the procedures proposed fall within the definition of special medical procedures.

34. 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.

35. 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.

36. 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".

37. 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.

38. 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, in which the relevant treatment was permitted.

39. I now turn to the evidence, following the considerations in Rule 4.09(2) although, for convenience, in a slightly different sequence.

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

40. Dr C was the first to diagnose Jamie. Dr C is a consultant child and adolescent psychiatrist, who has been associated with the hospital, a well renowned public hospital, for 30 years. He has had considerable experience working with children and adolescents with a range of gender identity development disorders. He is part of an inter-departmental psychiatric and endocrinology group that meets regularly to discuss matters of childhood gender identity, and he has regular liaison with a significant gender identity development disorder clinic in the United Kingdom.

41. Dr C has seen Jamie on a regular basis since she was referred by her general practitioner in July 2007. Jamie has attended approximately monthly. Dr C has met Jamie in sessions with her parents, her brother, and on her own.

42. Dr C described Jamie's social, emotional and cognitive development as typically within normal limits. He described Jamie's language and capacity to understand and describe complex concepts as very good, and noted that she has been performing well above average within her class group. He described Jamie as bright, engaging, and vivacious, with a keen sense of humour. Jamie is managing the academic requirements of school with ease. Socially, she is very popular and has friends amongst both boys and girls. Dr C noted that Jamie enjoys singing and performing and recording her voice. Her dream is to be a female pop singing star. She demonstrated performances for Dr C who said she performed in a "very feminine and creative way".

43. According to Dr C, Jamie has consistently described herself as identifying as a female from the first time they consulted in 2007. Since changing schools at the

beginning of 2009, Jamie has always worn female clothing, her hair has grown longer, and she has presented "unquestionably as a very attractive young girl."

44. Dr C described Jamie's parents as "initially very distressed about her predicament and unsure about how to proceed." He believed that the parents have continually attempted to support Jamie, without trying to influence or pressure her in her choice of gender identity.

45. Dr C was satisfied of Jamie's consistent and firm conviction that she is a girl within the body of a boy, and that all the information indicated a consistent female identification. He concluded that there was no evidence of any physical or genetic abnormality, nor of any other psychiatric disorder or major depressive or affective disorder. He had "no doubt" that Jamie meets criteria for the diagnosis of "childhood gender identity disorder (transsexual type)."

46. Professor N was asked to give a second opinion. Professor N is the director of a centre specialising in developmental psychiatry and psychology at a large teaching hospital. She has held a number of leadership positions in child psychiatry in this country, has extensive teaching, research and international consultancy experience, as well as a wide range of publications to her name.

47. On 12 January 2011, Professor N prepared a report in relation to Jamie. Professor N saw Jamie in the presence of her parents and brother as well as alone. The diagnostic conclusion was that Jamie "meets DSM-IV Criteria for the diagnosis of Gender Identity Disorder of childhood (302.6)". She demonstrated strong and persistent cross-gender identification and persistent discomfort with sex. Professor N noted Jamie's cross-gender identification as existing from early childhood, and that she has not evidenced any period of male role identification.

48. Dr C referred Jamie to endocrinologist Dr G in February 2009. Dr G is a senior endocrinologist at the same hospital as Dr C. He has provided clinical teaching for medical students over the past 29 years, is widely published, has delivered many international lectures, and has considerable experience in the area of treating children and adolescents with gender identity disorder. He noted Jamie as having "persistent and profound gender identity disorder of the transsexual type."

49. No-one has taken issue with the diagnosis.

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

50. When Dr G first saw Jamie in February 2009 he wrote in his notes that Jamie looked "convincingly female in every way." Nevertheless she had typical male genitalia with a normal penis and testes. Her chromosomes were those of a typical male. Dr G recorded Jamie's testicular volume, height, weight, pubic hair development and level of hormones. He has continued to make those

measurements, and on 22 February 2011 found that Jamie, at 10 years 9 months, was undergoing "rapid pubertal development". She had grown 3.4 centimetres in three months, and was experiencing the pubertal growth spurt that usually occurs in older boys.

51. A blood test, conducted a week before the hearing, showed Jamie's serum testosterone to have risen from 2.2 (an adolescent level) in February 2011, to 15 (an adult level). Dr G was concerned by the rapid rise, and conducted other tests to ensure there was no underlying pathology. He was satisfied that there was not. He said the rapid rise was consistent with his clinical assessment and Jamie's other symptoms, showing that she is now at stage four of the six stages of male puberty, the stage usually reached at about 14 years of age, and well beyond the stage usually recommended for the commencement of puberty suppression treatment.

52. In his 9 March 2011 affidavit, Dr G had already noted Jamie's facial appearance as becoming more masculine, and her eyebrows thickening. Although her voice had not yet deepened, Dr G believed it would not be long before it happened. He had noted Jamie's stage of pubic hair development having progressed from stage two to stage three, the penis was longer than when last examined, and the testicular volumes had increased.

53. It was on the basis of the rapid development then that Dr G requested the applicants' lawyers to contact the Court for a "very early hearing". Dr G expressed the need to start treatment within a month if possible.

54. At the hearing, in light of the very rapid changes in just a few weeks, Dr G said that if it were up to him, he would start treatment that afternoon. In his professional opinion, there was no time to lose. He recommended immediate treatment to prevent the psychological distress that Jamie would experience if male puberty were to progress. He noted Jamie was already finding the small amount of development that had occurred distressing. It was also to prevent "irreversible masculine changes" such as a deepening of her voice.

55. Dr G proposed treatment to start with Zoladex, a GnRH analogue, to block puberty. It is administered as a three-monthly subcutaneous implant, inserted under local anaesthetic. It was described by Dr G as routinely used in the hospital to treat children with precocious puberty, as well as patients with gender identity disorder. He described it as almost always effective in suppressing pituitary gonadotrophins, which then shut off testosterone production by the testes for as long as treatment is continued. In Dr G's experience, it has never caused any unwanted side-effects.

56. Dr G advised that the treatment effects a brief initial stimulation of pituitary gonadotrophins and testosterone. As one of the aims of treatment is to immediately prevent Jamie's voice from deepening, Dr G proposed a 50mg per day oral anti-androgenic drug (cyproterone acetate) in the first month, to block

the effects of the testosterone. It would not be needed once the gonadotrophins had been suppressed.

57. According to Dr G, Zoladex will slow the process of maturation and the growth plates of the long bones. Sperm production in the testes will also be arrested. Penile erections, which Jamie is currently experiencing and finding very distressing, will cease during the Zoladex treatment. Bone mineral density will increase during treatment.

58. The effects of Zoladex and the suppression of puberty last only while it is being given. The effects are reversible.

59. It is proposed to continue Zoladex until Jamie is about 16, in five or six years, when, according to the consensus guidelines published by the US Endocrine Society, she would start the second stage of treatment, taking oral oestrogen (probably Progynova). Dr G advised that in sufficient dosage, the oestrogen alone can suppress gonadotrophins and testosterone in a male, so that the GnRH analogue treatment would then no longer be required. However, to ensure gradual rather than accelerated breast development (which can result in unshapely breasts), he would start the oestrogen more gradually and build up to the adult dose over about a year. The GnRH analogue might therefore be needed to cover the additional year.

60. Oestrogen treatment brings about feminisation of the body. It also stimulates a marked increase in bone mineral density, which is beneficial. It has effects on the growth plates in the long bones, promoting the eventual closure of the growth plates, but in the doses Jamie would receive, the effect would be slow. Growth velocity may be stimulated in the first year of oestrogen administration, but would slow after one to two years. Jamie's final height would be less, by three to four centimetres, than if male puberty had been completed.

(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;

61. Having referred to Jamie's precocious onset of puberty, and its manifestations, psychiatrist Dr C gave specific evidence of the likely trauma to Jamie as a result of the profound and imminent changes.

62. Dr C reported that Jamie has told her parents that she sees herself as "a freak", feeling that she is a girl in a boy's body. She is aware of the dramatic changes occurring in her body and is frightened by them. She has had a very clear, consistent and unambiguous image of herself as an attractive girl developing into an attractive young woman. When she looks at her own male body, she

experiences a sense of disgust and revulsion which has been intensifying over recent times.

63. In Dr C's professional opinion, the concern is that it will lead to:

> …an increased likelihood of major mental disorder and behavioural difficulties, including severe depression and anxiety disorders and risk of self-harm.

64. Dr C referred to a documented increase in the rate of self-harm and suicidal behaviour amongst children and young people with gender identity disorder. He cited a UK study showing some 23% of such adolescents aged over twelve, harming themselves, or taking an overdose.

65. In Dr C's professional opinion, if the fully reversible stage one treatment is commenced, Jamie will have a further period of time to experience life as a girl. The feeling of being "a freak" will be significantly diminished, and she will experience "a significant sense of relief", knowing she will not have to endure any further masculinisation of her body. She will be very relieved by the cessation of spontaneous erections.

66. Dr C noted that in the medium term Jamie will continue living as a girl, and will continue feeling comfortable with her body.

67. Dr C noted a "hypothetical possibility" that treatment with Zoladex and subsequently with female hormones could lead to a diminution of male adolescent behavioural attributes such as increased assertiveness and aggression. Jamie sees that as an advantage since her self-image is of a "creative and gentle girl". Dr C emphasised the excellent support that Jamie has from her parents and brother, although she has not been pressured in any way by them to behave like a girl.

68. In a balanced assessment, Dr C reported that previously some clinicians felt it was important for children to experience pubertal development of their own biological sex, so that they knew what it was really like to be for example "a boy", before any changes were made. He noted however that at the major centres now treating such children, it was no longer considered necessary or appropriate in circumstances where a child has a strong and persistent conviction that they are of the opposite gender.

69. Dr C continued that:

> Rather, such children are likely to feel persistently traumatised by the experience of living in a body at variance with their inner gender identity. It is likely that as the child is happier with their own body, they are less stressed and disturbed and, should their sense of gender identity change, they are in a stronger position to make an appropriate transition.

70. In Jamie's case, Dr C noted that she has already experienced the early stages of male puberty as a consequence of its precocious onset. She has not shown any positive response to physiological and sexual changes with the development of male puberty. Dr C said this is one of the indicators that she is likely to persist with her female gender identification.

71. In a written question, the ICL asked Dr C about the consequences of the child ceasing treatment in the future. Dr C said he understood that the physiological effects of stage one treatment are fully reversible and that cessation of Zoladex would see the resumption of normal male pubertal development. He understood that the physical effects of stage two treatment with oestrogen are also reversible, except if there were significant breast development, it could require surgical treatment.

72. As to the emotional effect of ceasing Zoladex, Dr C said it would depend upon the circumstances. If Jamie herself decided that she does have a male gender identity, so that it were her choice to cease treatment, her emotional state would not be likely to be disrupted. She would need on-going psychotherapy, counselling, and family support through this process, but from what the psychiatrist has seen of Jamie's and her family's capacity for sharing their feelings and support, it is likely that it would be managed without major distress. However, if Zoladex were withdrawn against Jamie's will, and she had to endure male pubertal development while still experiencing herself as a female, Dr C described that as "a potentially devastating process" for Jamie.

73. Dr C said in the long term, suppression of male puberty will mean that Jamie can commence female hormone treatment should she wish to do so at around the age of 16 years, in order to induce feminisation of her body. A long term effect of suppression of male puberty is the greater likelihood that, as an adult, Jamie will be able to "pass" as a person of her desired gender. Without this treatment, it is likely that features such as larger muscles and hands, coarse facial features, and facial and body hair, would make it more difficult to be perceived by others as fully female, and would require extensive (and expensive) treatment, likely to be only partly successful.

74. If Jamie chose to cease stage two treatment, Dr C expected she would manage the transition without undue distress. She and her family would need guidance and support if Jamie stopped living amongst her family and peers as a girl, as she has done so from very early childhood. Dr C believed that Jamie and her parents would be able to manage that process. Again, if she were forced to cease treatment, it would be a major trauma putting her at significant psychological risk.

75. Professor N, in offering a second psychiatric opinion, confirmed that Jamie has a "stable female identity", and the experience of male puberty is likely to be "extremely disturbing". Professor N also referred to the research in relation to a

positive outcome of pubertal suppression, with a reduction in behavioural and emotional problems.

76. In her opinion, the use of puberty blockers would also allow for on-going psychological exploration of the gender issues, and further assessment for the appropriateness of stage two treatment at 16 years' of age.

77. Professor N said that suppressing male puberty is appropriate, and will prevent emotional and social distress. Jamie would be negatively impacted by developing a more male appearance, and it may have significant impact on her mood, self confidence and social functioning. The stage one treatment will "minimise the risk" of Jamie developing depression, anxiety and the related risk of self-harm and suicidal behaviour.

78. The endocrinologist Dr G said that if the treatment is delayed, the most likely consequence in the short term is that Jamie's voice will deepen. Citing the literature that the deepening of the voice correlates with testicular volume, Dr G advised that Jamie's voice could irreversibly deepen "very soon". In answer to a written question from the ICL, Dr G added that "there is no time for further delay in starting treatment if the aim is to prevent her voice from changing."

79. Dr G said that transsexual male-to-female adults who have gone through male puberty have to have speech therapy to hide their male voices. Some also have expensive surgery to the larynx in an effort to sound more feminine. Dr G emphasised that prevention would be better. He said that in his professional opinion as to Jamie's needs, "it would be most unfortunate to miss this once-in-a-lifetime opportunity to prevent it."

80. Dr G noted that without stage one treatment, Jamie would now start growing facial hair, and that already there is a faint shadow on her upper lip. He expected it would be a matter of months before this becomes obvious. He noted that transsexual adults who have not had the benefit of early intervention are forced to spend a great deal of money, and endure discomfort, having electrolysis to remove hair in the beard area. Prevention again is a far better option.

81. If stage one of the procedure is not carried out, Dr G expected that Jamie would be extremely frustrated and angry, as well as depressed. Life would be "intolerable", if she were forced to go through male puberty. Jamie is not conflicted about her gender. As far as she is concerned, she is female. She does not want to have to continue living in a male body. To her it seems "alien". Like the psychiatrists, Dr G referred to the risk factor for life-threatening behaviours.

82. Dr G saw no problems in carrying out the first stage of treatment. It is fully reversible. It has no side-effects. As he said, "Endocrinologists have been prescribing it for years in children much younger than [Jamie], to arrest precocious puberty". It would enable Jamie's mental development to proceed "normally", without the "terrible impediment" of gender dysphoria. Dr G cited

that blocking puberty at an early age has been shown in other centres to be beneficial, and is recommended in clinical guidelines published in 2009 by the US Endocrine Society.

83. The stage two oestrogen treatment would not be started for five to six years. Throughout that time Jamie would be seeing a mental health professional, and her thinking about gender identity will be closely monitored.

84. The part of the stage two treatment that warrants particular consideration is that the introduction of oestrogen will cause breast growth. If Jamie were thereafter to choose to live as a man, the breasts could only be removed by surgical intervention.

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

85. From Dr G's perspective, the alternative of just a behavioural approach to treatment would be unlikely to be beneficial. Jamie's physical changes would still be occurring, and they are the source of her distress. If a patient is in some way uncertain about what she wants, then a behavioural approach on its own can be appropriate, but Dr G emphasised that "this patient is in no way uncertain." Psychotherapy throughout the treatment is however essential.

86. The ICL specifically asked the psychiatrist Dr C as to whether there was an alternative less-invasive medical treatment. He expressed the opinion that the only alternative is to withhold hormonal treatment. He said that:

> …Paradoxically for [Jamie] this would be experienced as quite 'invasive' in itself as the unwanted masculinisation of her body will be experienced as an increasingly distressing perturbation and disruption of her sense of self. Other longer term medical treatments which oppose the actions of testosterone, such as cyproterone acetate, have additional side-effects which would make it inappropriate for other than brief treatment.

87. Dr C was also of the opinion that it would not be in Jamie's best interests to be treated by behavioural therapy alone, in the absence of the stage one and later stage two medical treatment. He said there is no research evidence to demonstrate that behavioural and psychological therapies cause a child to change their experience of their own gender identity.

88. Dr C explained that psychological therapies are however an important adjunct to help the child and family adjust to the child's gender identity dysphoria. Such therapies are designed to ensure that a child feels there is a full range of options available for the way she experiences her body and sense of self. At the same time, a child who feels pressured to deny and suppress their genuine cross-

gender identity is, according to Dr C, likely to experience "significant psychological stress and trauma."

89. The endocrinologist Dr G specifically considered alternative drugs that could be used to suppress gonadotrophin secretion. He said that the drugs administered before the introduction of long-acting GnRH analogues are now regarded as inferior. They have side-effects of weight gain and adrenal suppression. Otherwise, any intervention that fails to control testosterone levels would also fail to prevent deepening of the voice, and that would be a life-long problem if Jamie continues to wish to be identified as female.

(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

90. In considering whether a child is capable of making an informed decision, the authorities have adopted the principle in *Gillick v West Norfolk A.H.A* [1986] A.C.112, where the House of Lords held that a minor is capable of giving informed consent when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".

91. Jamie is still young, and younger than the majority of children who undertake this proposed treatment. Nevertheless, in the psychiatrist Dr C's opinion, Jamie is able to demonstrate an understanding "of the broad nature of the treatment proposed", namely that she will receive treatment with hormones which will affect and delay the development of the bodily changes of puberty. Dr C said Jamie understands that this will delay the growth in her penis and testicles, and that there will be a slowed body hair development and masculine-type bone growth.

92. Jamie is aware that subsequent treatment with female hormones, when she is older, may then affect her capacity for sperm generation. Dr C is satisfied that Jamie has been able to understand at an age-appropriate level the consequences of continued suppression of puberty, the later treatment with oestrogen, the possibility later of developing breasts, and of the surgery to create a vagina. Jamie has spoken about the possibility of marrying a man and adopting a child when she is an adult. Dr C said he does not believe Jamie understands how difficult that may be in our society, but it appears to be an appropriate and realistic option for this child.

93. Dr C concluded that although it is difficult for a child of Jamie's age to "completely understand" the implications for his life as a young adult, Jamie has "demonstrated capacity to think about issues such as the possibility of adopting or fostering children of her own." She wants to commence the female sex hormone treatment at around 16 in order to develop a more complete female appearance including the development of breasts.

94. Dr C concluded that Jamie voluntarily agrees to the commencement of treatment. She has "a good understanding of the essence of the treatment proposed and the potential side-effects." He believes that Jamie's capacity for understanding and making decisions is "more sophisticated than many of her age peers." She asks very appropriate questions. Her cognitive capacity is consistent with her high academic performance. She has a sophistication in her understanding of the world around her, and a "good grasp" of the basic physiological issues. However, Dr C said that at age 10½ years it is difficult to ensure that Jamie is able to understand "the full and extensive ramifications of such decisions, especially in the long term."

95. Jamie understands the stage one procedure with the regular injections of Zoladex. She understands it will entail a monthly injection under the skin. She is concerned about the pain that might result from these injections, but understands that the pain should be minimal after the administration of topical anaesthesia.

96. Dr C is satisfied that Jamie has also considered the alternative, which is to proceed through male puberty. He described Jamie as "terrified" of her voice changing, and she has given clear descriptions of the process of the removal of her penis and the fashioning of some sort of vagina, as she would seek in the future.

97. Dr C noted that Jamie clearly feels supported by her parents, who have been able to understand the full range of treatment possibilities and outcomes. In sessions with Dr C, the parents have always let Jamie know that they would be supportive of whatever decision she might make in the long term, including changing her mind and continuing life as a boy should she choose to do so in the future. Dr C is satisfied that Jamie has been free of any pressure.

98. Dr C summarised Jamie's capacity and understanding as follows:

> So in the sense that [Jamie] is aware of the exquisite predicament of the conflict between her experienced gender identity and biological gender, and of the options for treatment with Zoladex and later oestrogen, or of no medical treatment, I believe she is able to make an informed decision to commence treatment. [Jamie] has excellent cognitive and reasoning skills, and I believe that at a later stage, around the age of 16 years, she will also be

> able to clearly understand the range of treatment options available in particularly commencing female hormone treatment. I believe she also has the intellectual and emotional capacity to change her mind and inform her parents and carers to cease treatment at a later stage, should that be her desire.

99. Dr C concluded however that clearly Jamie does not have the level of maturity to be responsible for decisions of such gravity, but she does have a good understanding of the process involved and the potential risks and benefits. He said it was not appropriate for Jamie to make such decisions on her own. It is the parents' responsibility to make such decisions in consultation with Jamie.

100. Dr MW prepared the Family Report. In her professional opinion Jamie's wishes to undergo the treatment are "significant and persistent", and should "certainly be given weight in these proceedings." In Dr MW's opinion, the strength of Jamie's wishes was highlighted by her statement when she was asked what she would like to say to the court, when she said:

> I really really desperately need that treatment because without it I wouldn't be who I feel myself to be …and that would just be terrible…because for the rest of my life I couldn't be who I feel myself to be…and that would just be devastating…for me it would be an incomplete life…and I wouldn't feel good.

101. Dr MW commented that, although at almost 11 Jamie does not have the maturity and cognitive ability to fully understand the long-term realities and consequences of her decisions, it does appear that she has "a very good understanding" of what she wants, and of her gender identity and treatment, and a very good understanding of what is involved in the treatment she is requesting.

102. Importantly, as Dr C had reported, Dr MW found that Jamie listens to alternatives, understands that she will require on-going counselling, therapy, and support, and seems to freely express herself and her concerns and fears, seeking support and help when required. Dr MW also pointed to the consensus amongst Dr C, Professor N and Dr G, that Jamie understands and is aware of the risks and benefits of treatment and has made the decision because of her on-going and consistent desire and feelings of wanting to be female. His discussions with Jamie enabled Dr MW to reach the same view.

103. In paragraph 33 of her report, Dr MW quoted a number of Jamie's comments, and concluded that although she does not believe it is possible that Jamie has considered all the potential problems and issues that may arise, and that this would most probably be impossible for anyone no matter their age, she does appear to have the understanding of the realities of her life and the treatment.

104. Finally, although Dr MW was of the view that Jamie did not fully understand all the realities of life as a transsexual adult, nor the complexities and difficulties involved in for example adopting children, as the stage one procedure is fully reversible, without long-term effects on fertility, the child will be free to change her mind at a later date, when she is more cognitively able to grasp the long-term implications of the decision.

105. In summary, the experts agreed that Jamie agrees to the initial treatment, that she has a good understanding of it, and a mature and intelligent grasp on her situation. That said, at still shy of 11 years' old, it is not suggested she has a "full" understanding, at least when it comes to stage two of the treatment which would entail irreversible physiological feminisation, around six years' from now. The experts agreed that Jamie's understanding and views would need to be considered again closer to that time.

106. As to whether Jamie can make an "informed decision" to stage one of the treatment, the answer is that she probably can. Whilst I take that into account, I agree with Dr C that at Jamie's age, she still needs to be guided by her parents' decision. The finding however is clear, that Jamie herself has a good understanding of and ardently seeks the treatment to start straight away.

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

107. There was nothing in the extensive medical material to suggest other than that Jamie's parents are supportive of both stages of the proposed treatment, but also supportive of Jamie in whatever decision she ultimately makes, so that she would be free to stop the treatment if she chooses, or free to continue to the next phase when she is older.

108. Like Dr C, the Family Report writer was also impressed with Mr and Mrs S. She described them as:

> …extremely well-informed, articulate, intelligent, and insightful individuals, who appeared highly supportive of and committed to help [Jamie] deal with her disorder and the associated issues, in any way they possibly can.

109. She also said Mr and Mrs S were united and integrated in their approach, and supportive of each other. She said it seems they have had their doubts along the way, and have at times in the past been "confused, fearful, stressed, and anxious about what to do". After many discussions, and after living through the difficulties with Jamie, it seems they have slowly developed a better understanding of the issues. They unconditionally accept Jamie as she is, although there is still some anxiety and distress on occasion, and particularly a concern about the likely impact on Jamie if this treatment is not supported.

110. Dr MW said that at no time did she have the sense from the parents that they were either "indoctrinating in their approach or somehow glorifying the issues". She noted Dr C's report that he always looks for underlying issues and problems in the parents when diagnosing a child with gender identity disorder, but in this case there was nothing to suggest any significant personality or emotional problems in either parent. Dr MW said that, consistent with Dr C's view, it was also her professional opinion that Jamie is doing so well because she is so well supported by family and friends.

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

111. No-one argued against the stage one treatment being necessary for Jamie's welfare. She keenly seeks it. Her parents fully support her. Her treating medical practitioners were very clear about the need not only for treatment but for the treatment to be started on the most urgent basis. The second opinion from an eminent psychiatrist supported it. The Family Report writer recommended it as necessary for her welfare. The ICL supported it. Their arguments set out above, were compelling.

112. The decision now as to whether stage two of the treatment, in five or six years, will be necessary for Jamie's welfare, is a more difficult one. The Family Report writer recommended that the court's approval for that treatment should be deferred until closer to the time when the decision needs to be made. That is the course urged by the ICL. The parents, supported by the doctors, urged that it be seen as two stages of the one proposed treatment and that approval should be given now for both of those stages, rather than requiring the expense of further proceedings.

113. Dr C's evidence was that Jamie's welfare is likely to be promoted if she knows that she will have control over the decisions in relation to her own body and identity when she is older, without the need to return to court. Both he and Dr G emphasised that no decision would be made in relation to stage two of treatment for another five to six years, and then it would only proceed if Jamie were seeking the treatment, and the medical practitioners agreed that it would be in her best interests.

CONCLUSION

114. Jamie is a bright, happy, well-adjusted child from a loving family. She is blessed with a natural intelligence, a vivacious personality, thoughtful and caring parents, a loving supportive twin brother, and academic and musical abilities. The only area of difficulty for her in her childhood this far has been her long-standing gender identity disorder. Since she has lived as a girl, even the anxiety surrounding those issues has greatly reduced. She has been accepted as a girl and has continued to flourish in her school and home life.

115. The rapid onset of her male puberty has demanded some urgent decisions. The hospital where she is treated by a renowned psychiatrist and endocrinologist is willing to commence the stage one treatment to suppress male puberty, a position argued very strongly and convincingly by the treating practitioners. Her parents, who have agonised appropriately over the decision, fully support it. Jamie wants it to happen as soon as possible. She has been consistent in that view.

116. Jamie's best interests are the paramount consideration in the court's decision as to whether to permit the parents to approve the treatment on Jamie's behalf.

117. Section 60CC of the *Family Law Act* sets out the various matters to be taken into account by the court. Not all pertain to this particular issue. I take into account Jamie's strong and consistent views that she wants to commence treatment. She is sufficiently mature, intelligent and informed for considerable weight to be attached to her wishes. Her parents' views are important. I am satisfied that they are both very capable to attend to Jamie's needs.

118. The medical practitioners are united as to the risks to Jamie should she start to develop the male characteristics inevitable with the continuation of her rapidly developing male puberty. Her concerns about being teased and/or bullied as "a freak" are well-founded. She has been living as a girl and looks like a girl. Were she to become a girl with a deep voice, facial hair, a growing penis, body hair, and the large limbs of a male, she would be fundamentally distressed by those developments being so drastically at odds with her self-image, and her presentation, and would face very significant risks of behavioural issues and self-harm. The doctors were clear that the research supports that. Their concerns were endorsed by the Family Report writer. She would also be exposed to bullying, and distraction from her successful activities at school and outside.

119. Jamie's long-standing wishes, the fact of her close family members being able to support her needs, and the real risks to Jamie if this treatment were not commenced, assisted me in reaching the conclusion that the stage one treatment was in Jamie's best interests, and needed to commence as a matter of urgency.

120. The remaining but difficult issue relates to stage two of the treatment. I was referred to authorities where both stages of treatment have been approved at the one time. Two such cases were recently decided by me. I note however in those cases that the young people involved were aged 16 years' four months and almost 17 years' respectively, and stage two of the treatment was envisaged to start within a relatively short time after stage one. Another was in *Re Brodie* [2008] FamCA 334, a decision of Carter J. Although her Honour noted (at para 39) that this was the "first stage of an overall treatment plan which should be viewed as a single treatment", and that to do otherwise would be "an artifice", she did not in fact approve one continuous course of treatment, across the two stages, for 12-year-old Brodie. Her Honour approved stage one and determined

that the later stages of treatment would be dealt with "at different times and by subsequent applications".

121. In *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* 2004 FLC 93-175, Nicholson CJ, sitting as a trial Judge, held that a similar two stages of treatment should be regarded as "a single treatment plan". His Honour found (at para 188) that:

> …Compartmentalising the stages of treatment for the purposes of these proceedings would have an air of unreality about it.

122. Alex was aged 13 at the time.

123. In line with my own previous decisions, and those decisions of other single judges, I am satisfied that the two stages of treatment can be viewed as one treatment plan. That said, I am equally satisfied that whether the two stages of the one treatment plan should be approved at the same time depends on all the circumstances.

124. In *Brodie,* for example, the medical experts did not regard diagnosis as having been completed. Although there is not the same obstacle in this case, there is the unusual circumstance of a very young child, at 10, the youngest to be treated by the experts in this case. That means that decisions as to phase two of the treatment plan would not come into play for another five or six years, obviously a long way off and an extremely large proportion of this child's life. I cannot overlook that although it may be one treatment plan, it is simply not possible to project up to six years into the future as to whether or not stage two should be approved.

125. The ICL asked Dr C a number of questions aimed at understanding the chances of a child changing his or her mind between the stages of treatment. Dr C emphasised that the cause of a typical gender identity disorder is not known. He said it is understood that many of the children who present early in childhood with atypical gender identity development do not progress in adulthood to an on-going transsexual identity. He continued, however, that there is increasing research indicating that those children with early-onset gender identity disorder, whose cross-gender identity remains "fixed and persistent" through early childhood, puberty, and into adolescence, are more likely to progress to becoming on-going adult transsexuals.

126. The parents and doctors presented the case for approval at this point on the basis that if Jamie wants the relevant treatment when she is older and her parents and doctors consider it appropriate, then it should occur. On the other hand, if Jamie does not want the treatment then she will be supported by her parents and doctors, and the treatment will not occur. With respect, that dichotomy fails to deal with a wide and potentially far more complex spectrum of possibilities

between those two clear positions. It also fails to fully appreciate the court's role in cases of special medical procedures.

127. The argument that the stage two treatment will only be embarked upon if Jamie seeks it, and her parents and doctors support it as in her best interests, overlooks the court's role. The court is required to approve a special medical procedure. The two-phased medical procedure in this case requires approval, even if the child, her parents and doctors already agree, as they do in this case. The issue is whether the court can comfortably determine this 10-year-old child's best interests, and therefore approve a particular procedure or treatment, irreversible in nature, not due for six years.

128. .Although Dr C talked about it being likely that Jamie's trajectory is reasonably predictable, in the sense that her gender identity dysphoria has existed since early childhood, and she has now lived entirely as a girl for several years, it is impossible to predict how life will unfold for a 10-year-old child by the time she is a young person of around 16 years' of age. Although one hopes that her life will go from strength to strength, there are all sorts of vagaries and potential factors that may intervene. There is her own health, the health of her parents or brother, the relationship of her parents, her relationship with her parents, her relationships generally, her schooling, and/or advances in medical science, to name some obvious ones.

129. The parents' preference not to return to court is entirely understandable. They are likely to see court proceedings not only as a constraint on their freedom to determine, with Jamie, issues about which there has been a great deal of thinking, advice and soul-searching, but also as involving financial and emotional expense, with the risk of uncertainty for Jamie at an age and stage when it may be beneficial for her to feel empowered to participate in these decisions outside the shadow of the court.

130. I simply cannot determine in 2011, when Jamie is still only 10, what is likely to be in her best interests in 2016 or 2017 when she is aged sixteen.

131. If all things are equal, and Jamie remains determined to start stage two treatment, and her parents continue to understand and support her to be free of pressure to make her own decisions, and the treating medical practitioners continue in their view that it is in her best interests for the treatment to be administered, then my hope is that the court, mindful of the findings at this stage, will again be able to offer a fast resolution with minimal expense and anxiety for the family. If however the circumstances have changed in any significant way, it is appropriate for a judge to consider those circumstances closer to that time.

THE ORDERS

132. I have already made some orders on 28 March 2011. They included extensive orders as to the anonymisation of my Reasons for Judgments and orders. They

were deliberately detailed and restrictive, to ensure privacy for Jamie and her family, and protection from these sensitive personal issues being widely circulated. It could only be damaging for Jamie to be identified.

133. I ensured that the parties received one complete non-anonymised set of orders so that the hospital and medical practitioners could act upon it. I shall ensure the same occurs in relation to the outstanding order.

134. Subject to any contrary submissions, the only outstanding order is that the parents' application filed 10 January 20-11 shall be otherwise dismissed.

I certify that the preceding one hundred & thirty-four (134) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Dessau delivered on 6 April 2011.

Associate:

Date: 6 April 2011