

# CONSENT FOR MEDICAL TREATMENT OF TRANS YOUTH: A COMPARATIVE ANALYSIS OF THE LAW IN AUSTRALIA AND IN ENGLAND AND WALES

STEPH JOWETT\*, BEN MATHEWS\*\* AND JONATHAN HERRING\*\*\*

*Clinical and legal regulation of consent to medical treatment for trans youth, both binary and non-binary, is complex as well as controversial. In this article, we outline the clinical context in which consent is sought for gender-affirming medical treatment of trans youth in Australia and in England and Wales. Then, informed by an understanding of the developing evidence base behind early gender-affirming treatment, the lived experience of trans young people, and a developmental approach to capacity in decision-making regarding medical treatment, this article goes on to consider the justifiability of current legal regulation in this area. First, this article examines general principles in relation to consent for children's medical care, then charts the development of those principles through key cases that have shaped this particular area of law in Australia, England and Wales. These developments are then synthesised and compared in respect of the extent to which they promote or impede autonomous decision-making in the respective jurisdictions. We identify decisive similarities and differences between the jurisdictions, along with the likely practical implications for trans youth, their families, and treating doctors. Our analysis adds further weight to the growing consensus spanning the judiciary, doctors, legal scholars, and interest groups, that the law in Australia should be reformed to reduce unnecessary and harmful barriers to treatment for all trans youth.*

## I INTRODUCTION

Clinical and legal regulation of medical treatment for trans youth, both binary and non-binary, is complex and controversial. Trans<sup>1</sup> youth are increasingly attempting to exercise autonomy over their bodies, seeking medical treatment to align their experienced gender with their physical appearance. The question of whether children and young people are capable of making informed decisions about medical treatment in respect of their gender arouses considerable debate. In

\* Lecturer, Law School, Queensland University of Technology (QUT).

\*\* Professor, Law School, Queensland University of Technology (QUT).

\*\*\* Professor, Exeter College, Oxford. The authors wish to acknowledge the research assistance of Sinead Prince in the preparation of this article.

1 'Trans' is used here as an umbrella term to refer to individuals whose gender does not align with their sex assigned at birth. Individuals may self-identify as trans, non-binary, genderqueer, agender (genderless), or employ other terms. This is consistent with the terminology used by the Australian Professional Association for Trans Health ('AusPATH') and the relevant clinical guidelines and standards of care in Australia: Michelle Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Guidelines Version 1.3, November 2020) ('*Australian Guidelines*').

England and Wales, as well as Australia and many other countries, it is also increasingly political. Clinicians working in this area are ‘acutely alert to the particular mix of scientific understanding, clinical judgement and moral sensitivity’ that accompanies it.<sup>2</sup> The legal framework underpinning such clinical practice can provide a pathway for informed consent from a trans young person or their parent, or place considerable barriers in front of it. Access to gender-affirming treatment in Australia, and the nature and extent of gatekeeping within clinical and legal realms, has long been subject to criticism among legal scholars,<sup>3</sup> medical practitioners,<sup>4</sup> and the judiciary.<sup>5</sup> Scrutiny over the provision and regulation of gender-affirming treatment for youth in England and Wales has also picked up steam in recent years.<sup>6</sup>

- 2 Bernadette Wren, ‘Ethical Issues Arising in the Provision of Medical Interventions for Gender Diverse Children and Adolescents’ (2019) 24(2) *Clinical Child Psychology and Psychiatry* 203, 205.
- 3 Stephanie Jowett and Fiona Kelly, ‘*Re Imogen*: A Step in the Wrong Direction’ (2021) 34(1) *Australian Journal of Family Law* 31; Georgina Dimopoulos and Michelle Taylor-Sands, ‘*Re Imogen*: The Role of the Family Court of Australia in Disputes over Gender Dysphoria Treatment’ (2021) 39(1) *Monash Bioethics Review* 42; Felicity Bell, ‘Children with Gender Dysphoria and the Jurisdiction of the Family Court’ (2015) 38(2) *University of New South Wales Law Journal* 426; Fiona Kelly, ‘Australian Children Living with Gender Dysphoria: Does the Family Court Have a Role to Play?’ (2014) 22(1) *Journal of Law and Medicine* 105; Fiona Kelly, ‘Treating the Transgendered Child: The Full Court’s Decision in *Re Jamie*’ (2014) 28(1) *Australian Journal of Family Law* 83 (‘Treating the Transgendered Child’); Katherine France, ‘Let Me Be Me: Parental Responsibility, Gillick Competence, and Transgender Minors’ Access to Hormone Treatments’ (2014) 4(4) *Family Law Review* 227. Cf Patrick Parkinson, ‘Adolescent Gender Dysphoria and the Informed Consent Model of Care’ (2021) 28(3) *Journal of Law and Medicine* 734; Mike O’Connor and Bill Madden, ‘In the Footsteps of Teiresias: Treatment for Gender Dysphoria in Children and the Role of the Courts’ (2019) 27(1) *Journal of Law and Medicine* 149.
- 4 Fiona Kelly et al, ‘Parental Consent and the Treatment of Transgender Youth: The Impact of *Re Imogen*’ (2022) 216(5) *Medical Journal of Australia* 219 (‘The Impact of *Re Imogen*’); Michelle Telfer et al, ‘Transgender Adolescents and Legal Reform: How Improved Access to Healthcare Was Achieved through Medical, Legal and Community Collaboration’ (2018) 54(10) *Journal of Paediatrics and Child Health* 1096; Michelle Telfer, Michelle Tollit and Debi Feldman, ‘Transformation of Health-Care and Legal Systems for the Transgender Population: The Need for Change in Australia’ (2015) 51(11) *Journal of Paediatrics and Child Health* 1051; Jacqueline K Hewitt et al, ‘Hormone Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents’ (2012) 196(9) *Medical Journal of Australia* 578.
- 5 Mark Bannerman, ‘Family Court Chief Justice Calls for Rethink on How High Court Handles Cases Involving Transgender Children’, *ABC News* (online, 18 November 2014) <[http://www.abc.net.au/news/2014-11-17/chief-justice-calls-for-rethink-on-transgender-childrens-cases/5894698?WT.mc\\_id=Corp\\_News-Nov2014%7CNews-Nov2014\\_FBP%7Cabcnews](http://www.abc.net.au/news/2014-11-17/chief-justice-calls-for-rethink-on-transgender-childrens-cases/5894698?WT.mc_id=Corp_News-Nov2014%7CNews-Nov2014_FBP%7Cabcnews)>; Justice Steven Strickland, ‘To Treat or Not to Treat: Legal Responses to Transgender Young People’ (Conference Paper, Association of Family and Conciliation Courts Annual Conference, 28 May 2014); Justice Steven Strickland, ‘To Treat or Not to Treat: Legal Responses to Transgender Young People Revisited’ (Conference Paper, Association of Family and Conciliation Courts Australian Chapter Conference, 14 August 2015); *Re Martin* [2015] FamCA 1189, [38] (Bennett J) (‘*Re Martin*’); *Re Lucas* [2016] FamCA 1129, [72]–[73] (Tree J).
- 6 See discussion in Hannah Hirst, ‘The Legal Rights and Wrongs of Puberty Blocking in England’ (2021) 33(2) *Child and Family Law Quarterly* 115.

Access to medical treatment for trans youth has occupied a dynamic legal landscape in Australia since 2004. Australian law has imposed significant barriers to accessing treatment, requiring applications to the Family Court of Australia for consent, authorisation, or assessment of a young person's competence.<sup>7</sup> Legal regulation of access to healthcare for trans youth, and any barriers the law might present, warrants scrutiny for many reasons, including the fact that the legal process in Australia has been found to harm trans youth and their families.<sup>8</sup> Further, the scientific evidence base demonstrates gender-affirming treatment is associated with beneficial therapeutic outcomes,<sup>9</sup> including a lower lifetime risk of suicide.<sup>10</sup> Shifting legal principles sit alongside a developing medical understanding of the phenomenon of gender diversity, the experience of trans young people, and the medical treatment that may be sought by or for them.

Until recently, the legal framework in England and Wales had not grappled with questions of mature trans young people's consent in this context, relying on legal principles of general application to medical treatment decisions.<sup>11</sup> However, notably, the recent decisions in the High Court (Divisional) and the Court of Appeal in *Bell v Tavistock and Portman NHS Foundation Trust* (collectively referred to hereafter as '*Bell*')<sup>12</sup> and *AB v CD*<sup>13</sup> have provided context-specific guidance as to the applicable legal principles in that jurisdiction also.

- 7 Malcolm K Smith and Ben Mathews, 'Treatment for Gender Dysphoria in Children: The New Legal, Ethical and Clinical Landscape' (2015) 202(2) *Medical Journal of Australia* 102, 102.
- 8 See Annelou LC de Vries et al, 'Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment' (2014) 134(4) *Pediatrics* 696 ('Outcome after Puberty Suppression and Gender Reassignment').
- 9 See *ibid.*
- 10 Jack L Turban et al, 'Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation' (2020) 145(2) *Pediatrics* e20191725:1–8 ('Pubertal Suppression and Risk of Suicidal Ideation'); Jack L Turban et al, 'Access to Gender-Affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults' (2022) 17(1) *PLoS One* e0261039:1–15 ('Access to Gender-Affirming Hormones and Mental Health Outcomes').
- 11 For the purposes of consent to medical treatment, England and Wales are effectively a single legal jurisdiction: *Government of Wales Act 2006* (UK) sch 7A s 8. For a discussion of the legal principles pre-dating recent case law developments, see Jonathan Herring et al, *Gender Dysphoria Treatment and Consent by Children and Young People: English and Welsh Statutes and Case Law* (Oxford Pro Bono Publico, June 2018) <[https://www.law.ox.ac.uk/sites/files/oxlaw/4.\\_gender\\_dysphoria\\_treatment\\_and\\_consent\\_by\\_children\\_and\\_young\\_people.pdf](https://www.law.ox.ac.uk/sites/files/oxlaw/4._gender_dysphoria_treatment_and_consent_by_children_and_young_people.pdf)>.
- 12 *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) ('*Bell Divisional Court*').
- 13 [2021] EWHC 741 (Fam) ('*AB v CD*').

Previous scholarship has considered the law in Australia,<sup>14</sup> and the law in England and Wales.<sup>15</sup> However, there is a need for comparative scholarly research comparing the significant recent developments in the respective jurisdictions.<sup>16</sup> This article employs a comparative lens to analysis of the legal principles in Australia, and in England and Wales, including the legal power of parents and mature trans young people to consent to medical treatment affirming the young person's gender. We identify decisive similarities and differences between the jurisdictions, along with the likely practical implications for trans youth, their families, and treating doctors. An examination of the differences between the law in Australia and the law in England and Wales is particularly interesting because, in large part, the law governing consent by and for children stems from a common source, the 1986 House of Lords decision in *Gillick v West Norfolk AHA* ('*Gillick*').<sup>17</sup> Divergence in approach, despite the common genesis, suggests legal reasoning has been influenced in the respective jurisdictions by three important factors: a variation in preference for competing bioethical values in this area; different interpretations and applications of the developmental literature; and different interpretations of the medical literature on trans healthcare.

In Part II, we outline the clinical context in which consent is sought for gender-affirming medical treatment of trans youth in the respective jurisdictions. This is followed in Parts III–V by a synthesis and critical comparison of the legal frameworks governing consent by young people in Australia and in England and Wales. In Part III, we outline general legal principles governing consent by mature minors to medical treatment from both jurisdictions. In Part IV, we present a brief review of the case law that has considered the application of those general principles to the context of trans youth. In Part V, we undertake a detailed synthesis and comparative analysis of how those case law principles operate to govern the particular setting of consent to gender-affirming treatment in Australia and in England and Wales, and determine the extent to which they promote or impede autonomous decision-making in the respective jurisdictions.

- 14 Kelly et al, 'The Impact of *Re Imogen*' (n 4); Calina Ouliaris, 'Consent for Treatment of Gender Dysphoria in Minors: Evolving Clinical and Legal Frameworks' (2022) 216(5) *Medical Journal of Australia* 230; Dimopoulos and Taylor-Sands (n 3); Georgina Dimopoulos, 'Rethinking *Re Kelvin*: A Children's Rights Perspective on the "Greatest Advancement in Transgender Rights" for Australian Children' (2021) 44(2) *University of New South Wales Law Journal* 637; Jowett and Kelly (n 3); Stephanie Jowett and Ben Mathews, 'Current Legal and Clinical Framework for Treatment of Trans and Gender Diverse Youth in Australia' (2020) 56(12) *Journal of Paediatrics and Child Health* 1856; Kelly, 'Treating the Transgendered Child' (n 3); France (n 3); Bell (n 3).
- 15 Cameron Beattie, 'High Court Should Not Restrict Access to Puberty Blockers for Minors' (2022) 48(1) *Journal of Medical Ethics* 71; Hirst (n 6); Lauren Notini, 'Bell v Tavistock: Why the Assent Model Is the Most Appropriate for Decisions Regarding Puberty Suppression for Transgender and Gender Diverse Youth' (2021) 28(3) *Journal of Law and Medicine* 632; Annelou LC de Vries et al, 'Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing Current Knowledge and Uncertainties in Decisions about Gender-Related Treatment for Transgender Adolescents' (2021) 22(3) *International Journal of Transgender Health* 217; Herring et al (n 11).
- 16 See Malcolm K Smith, 'The Requirement for Trans and Gender Diverse Youth to Seek Court Approval for the Commencement of Hormone Treatment: A Comparison of Australian Jurisprudence with the English Decision in *Bell*' [2022] *Medical Law Review* 1.
- 17 [1986] AC 112 ('*Gillick*').

This article contributes to knowledge by identifying similarities and differences in the respective jurisdictions, and their potential significance. This is especially so in the application and operationalisation of the *Gillick* competence principle. In doing so, it examines and compares the extent to which trans youth face gatekeeping by the law in accessing gender-affirming medical treatment.<sup>18</sup> Critical analysis of the law in this area is warranted due to the enormous impact it can have on the health and psychosocial wellbeing of trans youth, but also for the broader implications that it may have on the legal rights of young people generally, their ability to provide consent and exercise bodily autonomy in relation to medical treatment. Informed by an understanding of the developing evidence base behind early gender-affirming treatment, the lived experience of trans young people, and developmental approach to capacity in decision-making regarding medical treatment, it is argued that insights into the justifiability of differences between the legal frameworks could inform law reform to reduce unnecessary and harmful barriers to gender-affirming treatment for trans youth.

## II CLINICAL CONTEXT: ACCESSING GENDER-AFFIRMING CARE

### A Gender-Affirming Medical Treatment for Trans Youth

Trans youth, both binary and non-binary, experience a lack of concordance between their assigned gender at birth and their experienced gender.<sup>19</sup> While trans is used as an umbrella term, individuals may self-identify as being trans or transgender, gender fluid, genderqueer, agender, non-binary, or in other ways.<sup>20</sup> Trans youth may experience clinically significant distress associated with that incongruence, known as ‘gender dysphoria’ under the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (‘*DSM-5*’).<sup>21</sup> Trans youth may seek forms of medical treatment to affirm their gender, but not always.<sup>22</sup> There is an increase in

18 Florence Ashley, ‘Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising’ (2019) 45(7) *Journal of Medical Ethics* 480.

19 Telfer et al, *Australian Guidelines* (n 1) 4.

20 See Jos Twist and Nastasja M de Graaf, ‘Gender Diversity and Non-Binary Presentations in Young People Attending the United Kingdom’s National Gender Identity Development Service’ (2019) 24(2) *Clinical Child Psychology and Psychiatry* 277.

21 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Publishing, 5<sup>th</sup> ed, 2013) 452–3. See also ‘ICD-11: International Classification of Diseases 11<sup>th</sup> Revision’, *World Health Organisation* (Web Page) <<https://icd.who.int/en>>.

22 E Coleman et al, ‘Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7’ (2012) 13(4) *International Journal of Transgenderism* 165, 170–1 (‘Standards of Care Version 7’); Nastasja M de Graaf and Polly Carmichael, ‘Reflections on Emerging Trends in Clinical Work with Gender Diverse Children and Adolescents’ (2019) 24(2) *Clinical Child Psychology and Psychiatry* 353, 353.

trans youth seeking treatment from specialised gender clinics in Australia,<sup>23</sup> as well as in England and Wales.<sup>24</sup> This is in line with increased presentation at gender clinics internationally.<sup>25</sup>

While there is a dearth of longitudinal data, there is growing evidence that gender-affirming treatment is associated with improvement in psychosocial wellbeing of trans youth, whereas delay or lack of treatment is associated with detrimental and irreversible pubertal development, and increase or continuation of psychosocial distress.<sup>26</sup> This is particularly concerning as trans youth experience a high psychosocial burden and have increased likelihood of self-harm and suicide over the general population.<sup>27</sup>

In Australia, medical treatment for trans youth is predominantly accessed through specialised multidisciplinary gender clinics at publicly funded hospitals in several Australian states and territories, following referral from their general physician ('GP').<sup>28</sup> However, youth living in rural and regional areas may not be able to

23 Hewitt et al (n 4).

24 Gary Butler et al, 'Assessment and Support of Children and Adolescents with Gender Dysphoria' (2018) 103(7) *Archives of Disease in Childhood* 631, 636; 'Referrals to GIDS, Financial Years 2010–11 to 2021–22', *GIDS: Gender Identity Development Service* (Web Page, 7 June 2022) <<https://gids.nhs.uk/number-referrals/>>; de Graaf and Carmichael (n 22) 360.

25 In Spain: María Fernández et al, 'New Perspectives in the Hormonal Treatment of Gender Dysphoria in Adolescence' (2015) 43(1) *Actas Españolas de Psiquiatría* 24, 25. In the United States: Melinda Chen, John Fuqua and Erica A Eugster, 'Characteristics of Referrals for Gender Dysphoria over a 13-Year Period' (2016) 58(3) *Journal of Adolescent Health* 369. In Canada: Karine Khatchadourian, Shazhan Amed and Daniel L Metzger, 'Clinical Management of Youth with Gender Dysphoria in Vancouver' (2014) 164(4) *Journal of Pediatrics* 906; Kenneth J Zucker et al, 'Is Gender Identity Disorder in Adolescents Coming Out of the Closet?' (2008) 34(4) *Journal of Sex and Marital Therapy* 287; Hayley Wood et al, 'Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation' (2013) 39(1) *Journal of Sex and Marital Therapy* 1; Madison Aitken et al, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *Journal of Sexual Medicine* 756, 758. In Ireland: Helen O'Callaghan, 'Identity Politics: Why Transgender Children Need Legal Recognition', *Irish Examiner* (online, 28 September 2018) <<https://www.irishexaminer.com/breakingnews/lifestyle/healthandlife/identity-politics-why-transgender-children-need-legal-recognition-871956.html>>; Ciaran Judge et al, 'Gender Dysphoria: Prevalence and Co-Morbidities in an Irish Adult Population' (2014) 5(87) *Frontiers in Endocrinology* 1. There has also been an increase in the number of specialised paediatric gender clinics. For example, in the United States and Canada, see Sam Hsieh and Jennifer Leininger, 'Resource List: Clinical Care Programs for Gender-Nonconforming Children and Adolescents' (2014) 43(6) *Pediatric Annals* 238.

26 See de Vries et al, 'Outcome after Puberty Suppression and Gender Reassignment' (n 8); Rosalia Costa et al, 'Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria' (2015) 12(11) *Journal of Sexual Medicine* 2206; Turban et al, 'Pubertal Suppression and Risk of Suicidal Ideation' (n 10); Turban et al, 'Access to Gender-Affirming Hormones and Mental Health Outcomes' (n 10).

27 Penelope Strauss et al, 'Mental Health Issues and Complex Experiences of Abuse among Trans and Gender Diverse Young People: Findings from Trans Pathways' (2020) 7(3) *LGBT Health* 128.

28 Before legal developments in 2020, some Australian GPs were offering care on the basis of the 'informed consent model' to trans youth without requiring multidisciplinary assessment, though

readily access metropolitan centres and thus seek care primarily through their local GP as part of a shared care arrangement with hospital services.<sup>29</sup>

Trans youth in England and Wales seeking publicly-funded treatment may be referred to the Gender Identity Development Service ('GIDS') at the Tavistock and Portman NHS Foundation Trust ('Tavistock') for assessment.<sup>30</sup> The function of the GIDS is to conduct assessments to determine suitability for referral, rather than to prescribe treatment itself; a youth who is assessed as suitable may then be referred to one of two National Health Service ('NHS') trusts in London and Leeds whose clinicians may prescribe medical treatment. This centralised model of care is set to change in 2023, shifting to a distributed regional care model better able to cope with the pace of referrals; increasing capacity and improving access to care.<sup>31</sup> In both jurisdictions, trans youth may seek privately funded medical care through other avenues, though some GPs may be reluctant to provide what is considered by some to be complex care.<sup>32</sup>

## B Clinical Guidelines and Standards of Care

Medical treatment for trans youth is most often a multidisciplinary endeavour, involving pediatricians, psychiatrists, psychologists, endocrinologists, and GPs, among others. Clinicians in this area of medicine are guided in their treatment of trans youth by clinical best practice guidelines and standards of care documents. In Australia, a leading provider of gender health services to adolescents is the Royal Children's Hospital Melbourne, in the state of Victoria.<sup>33</sup> The hospital has released guidelines for clinical best practice, with the input of specialists from gender clinics across Australia, and are endorsed by the Australian Professional Association for Trans Health ('AusPATH').<sup>34</sup> The *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*

this appears to no longer be happening in practice: see Parkinson (n 3). Updated guidance can be found on TransHub about how this approach in Australia limits the practice of the model to those aged 18 years and older: see 'Informed Consent', *TransHub* (Web Page, 2021) <<https://www.transhub.org.au/informed-consent>>.

29 Telfer et al, *Australian Guidelines* (n 1) 21, 26.

30 'About Us', *GIDS: Gender Identity Development Service* (Web Page, 2023) <<http://gids.nhs.uk/about-us>>.

31 'Regional Model for Gender Care Announced for Children and Young People', *The Tavistock and Portman NHS Foundation Trust* (Web Page, 28 July 2022) <<http://tavistockandportman.nhs.uk/about-us/news/stories/regional-model-for-gender-care-announced-for-children-and-young-people/>>.

32 Sally Howard, 'The Struggle for GPs to Get the Right Care for Patients with Gender Dysphoria' (2020) 368 *British Medical Journal* m215:1–2; Helen Webberley, 'Re: The Struggle for GPs to Get the Right Care for Patients with Gender Dysphoria', *British Medical Journal* (online, 24 January 2020) <<https://www.bmj.com/content/368/bmj.m215/tr>>.

33 'Adolescent Medicine: Gender Service', *Royal Children's Hospital Melbourne* (Web Page) <<https://www.rch.org.au/adolescent-medicine/gender-service/>>.

34 Telfer et al, *Australian Guidelines* (n 1).

(‘*Australian Guidelines*’) were, when first published in 2018,<sup>35</sup> the first globally to focus exclusively on treating youth.<sup>36</sup> No equivalent set of national guidelines currently exists in England and Wales. However, Butler et al report that the GIDS follows a schedule for the provision of services, taking into account international treatment guidelines from World Professional Association for Transgender Health (‘WPATH’) and the Endocrine Society.<sup>37</sup>

Both the *Australian Guidelines* and the GIDS protocol outline treatment encompassing two main forms for adolescents who meet the *DSM-5* criteria for gender dysphoria. The first involves pubertal suppression through use of gonadotrophin-releasing hormone (‘GnRH’) analogues to halt or delay pubertal development (stage 1).<sup>38</sup> The second involves the administration of feminising (oestrogen) or masculinising (testosterone) hormones to induce development of the secondary sex characteristics associated with the desired gender (stage 2).<sup>39</sup> The *Australian Guidelines* do not prescribe an age threshold for commencing feminising or masculinising hormones, due to insufficient evidence supporting one.<sup>40</sup> In England and Wales, however, the GIDS will only refer for gender-affirming hormone interventions those aged 16 years old and over.<sup>41</sup> The latter approach aligns with older, more conservative, international treatment guidelines such as the 2012 WPATH *Standards of Care* (Version 7)<sup>42</sup> with newer guidelines, such as the *Australian Guidelines* and the 2022 WPATH *Standards of Care* (Version 8),<sup>43</sup> prioritising a more individualised approach.<sup>44</sup>

35 Michelle Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (Guidelines Version 1.1, 2018).

36 Rebecca Akkermans, ‘Michelle Telfer’ (2019) 3(8) *Lancet: Child and Adolescent Health* 524, 524.

37 Butler et al (n 24) 631, citing Coleman et al, ‘Standards of Care Version 7’ (n 22) and Wylie C Hembree et al, ‘Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society\* Clinical Practice Guideline’ (2017) 102(11) *Journal of Clinical Endocrinology and Metabolism* 3869.

38 Telfer et al, *Australian Guidelines* (n 1) 15.

39 Ibid 16–17.

40 Michelle M Telfer et al, ‘Australian Standards of Care and Treatment Guidelines for Transgender and Gender Diverse Children and Adolescents’ (2018) 209(3) *Medical Journal of Australia* 132, 134–5; Telfer et al, *Australian Guidelines* (n 1) 17.

41 ‘Puberty and Physical Intervention’, *GIDS: Gender Identity Development Service* (Web Page, 2023) <<https://gids.nhs.uk/puberty-and-physical-intervention>> (‘GIDS Puberty and Physical Intervention’).

42 WPATH, *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People* (Guidelines Version 7, 2011).

43 E Coleman et al, ‘Standards of Care for the Health of Transgender and Gender Diverse People, Version 8’ (2022) 23 (Supp 1) *International Journal of Transgender Health* S1.

44 See also Madeline B Deutsch (ed), *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* (University of California, San Francisco, 2<sup>nd</sup> ed, 2016).



In addition to hormonal interventions, some surgical interventions may be recommended for trans youth under the age of 18 in Australia (stage 3). This includes chest reconstructive or ‘top’ surgery for trans masculine youth, aimed at attaining the phenotypic appearance congruent with the desired gender.<sup>45</sup> In England and Wales, no surgical interventions are recommended or commenced during adolescence by the GIDS protocol.<sup>46</sup> Notably, the medical intervention, or combination of interventions that an individual may desire to relieve distress and/or feel concordance between their body and experienced gender is not the same for all. Some individuals may desire a combination of hormonal and/or surgical interventions, and some may desire neither. The *Australian Guidelines* emphasise that treatment, and timing of treatment, be individualised.<sup>47</sup>

In both jurisdictions, the role of guidelines and clinical processes in performing a regulatory ‘gatekeeping’ function, through clinical eligibility criteria and other policies,<sup>48</sup> has been the subject of significant criticism. In Australia, calls in 2019 for an inquiry into the provision of gender-affirming care were rejected in April 2020, with the Federal Health Minister heeding the advice of the Royal Australian College of Physicians (‘RACP’) and stating that a national inquiry would not increase scientific understanding and posed a risk of harm to already vulnerable trans young people, instead calling for nationally consistent healthcare provision.<sup>49</sup> To date, this call and response has not led to any particular changes in the Australian clinical context.

In England and Wales, the GIDS has been criticised for both ‘fast-tracking’ children for treatment, and, conversely, for subjecting others to lengthy waiting times and consultations.<sup>50</sup> In late 2020, the Independent Review of Gender Identity Services for Children and Young People (‘Cass Review’) was commissioned by the NHS to make ‘recommendations about the services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence’.<sup>51</sup> The Cass Review’s interim report was published in 2022 and outlined various concerns about service provision, including increasingly long wait lists and workload, leading to a recommendation that the

45 Telfer et al, *Australian Guidelines* (n 1) 25.

46 ‘GIDS Puberty and Physical Intervention’ (n 41).

47 Telfer et al, *Australian Guidelines* (n 1) 5.

48 Wren (n 2) 204.

49 Farrah Tomazin, ‘Hunt Rules Out Trans Inquiry, Wants Nationally Consistent Care’, *The Sydney Morning Herald* (online, 18 April 2020) <<https://www.smh.com.au/national/hunt-rules-out-trans-inquiry-wants-nationally-consistent-care-20200418-p54113.html>>.

50 Jamie Doward, ‘Gender Identity Clinic Accused of Fast-Tracking Young Adults’, *The Observer* (online, 4 November 2018) <<https://www.theguardian.com/society/2018/nov/03/tavistock-centre-gender-identity-clinic-accused-fast-tracking-young-adults>>; Jamie Doward, ‘Governor of Tavistock Foundation Quits over Damning Report into Gender Identity Clinic’, *The Observer* (online, 24 February 2019) <<https://www.theguardian.com/society/2019/feb/23/child-transgender-service-governor-quits-chaos>>.

51 ‘Terms of Reference’, *The Cass Review* (Web Page) <<https://cass.independent-review.uk/about-the-review/terms-of-reference/>>.

service model in England and Wales shift from a single specialist service (GIDS) to a distributed model based in regional hubs.<sup>52</sup> Further changes are expected to be recommended when the Cass Review hands down its final report.

Legal requirements and guidance from case law in both Australia and England and Wales have impacted the ability and willingness of physicians to prescribe treatment to young trans people, that arguably go beyond what is required by law. In England and Wales, the NHS has been responsive to case law in its policy and procedures. In December 2020, the NHS Service Specification for the GIDS was amended following the High Court judgement of *Bell*.<sup>53</sup> The *Bell* case involved judicial review of the lawfulness of the GIDS' provision of puberty blockers to trans young people under the age of 18. The Service Specification provided that, for those under 16 years of age, referrals to the GIDS should not be made unless there is a 'best interests' order made by the Court concerning the young person.<sup>54</sup> For those under 16 and receiving pubertal blockers at the time of the change, their lead clinician is required to assess and then either make a court application for a best interests order or safely withdraw the medication.<sup>55</sup> Further, for those aged 16 or 17 years old, provided they have capacity and their clinician 'considers the treatment to be in the patient's best interests, and there is no parental dispute about intervention, treatment may proceed'.<sup>56</sup> Where the administration of gender-affirming hormones is being considered for a young person aged 16 or over, or they are already receiving them, the patient's lead clinician is 'required to review every such patient's individual circumstances, and to consider an application to the Court (through their NHS provider) for final determination of that individual's needs if there is doubt about the patient's "best interests"'.<sup>57</sup> In Australia, those developments prompted one hospital in Perth to require 'in all cases of treatment for Gender Dysphoria an application ... to the Court seeking permission for treatment to proceed', reflecting the Divisional Court's position in *Bell*, despite those applications not being legally necessary.<sup>58</sup>

52 *The Cass Review: Independent Review of Gender Identity Services for Children and Young People* (Interim Report, February 2022) 20 <<https://cass.independent-review.uk/publications/interim-report/>>.

53 'Amendments to Gender Identity Development Service Specification for Children and Adolescents', *NHS England* (Web Page, 2020) <<https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-Identity-Development-Service-Specification-for-Children-and-Adolescents.pdf>>, archived at <<https://web.archive.org/web/20210106121735/https://www.england.nhs.uk/wp-content/uploads/2020/12/Amendment-to-Gender-Identity-Development-Service-Specification-for-Children-and-Adolescents.pdf>> ('Amendments to GIDS Specification 2020'); *Bell Divisional Court* (n 12). Note this case was overturned on appeal: *Bell v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363 ('*Bell Appeal*'). See below Part IV(B)(2)–(4).

54 'Amendments to GIDS Specification 2020' (n 53) 1.

55 *Ibid.*

56 *Ibid.* 2.

57 *Ibid.*

58 *Re G2* [2021] FCWA 98, [29]. This approach has resulted in several applications to the Court in situations which did not strictly require court involvement. See also *Re G3* [2021] FCWA 99, [28].

Following the Divisional Court's judgement in *Bell* being reversed on appeal in 2021,<sup>59</sup> the NHS amended their Service Specification for the GIDS to acknowledge that youth over 16 years old are able to give legally effective consent.<sup>60</sup> For those under 16 years, the Service Specification states that the processes followed by the GIDS would be 'assured by an independent Multi-Professional Review Group' and where the group was satisfied that processes are appropriately followed 'there is no requirement for the Tavistock and Portman NHS Foundation Trust to seek a prior Best Interest order from the Court in regard to an individual'.<sup>61</sup> Further, for those under 16, parental consent is also sought. It is unclear what impact the absence of parental assent or the presence of parental dissent would have in practice. Butler et al note that '[i]f the parents or carers object to treatment, this poses a complex ethical and social challenge'.<sup>62</sup> At the time of writing, the NHS were seeking public consultation over a revised Interim Service Specification for GIDS.<sup>63</sup> In Australia, the Perth hospital service's approach has since been amended, though does still require court application in situations where it is not legally required, such as where a young person seeks stage 2 treatment but they are not *Gillick* competent; parental consent will not satisfy the service's policy.<sup>64</sup> The impacts of legal developments in this area on clinical practice are immense.

### **C Scientific Knowledge on Adolescent Decision-Making Capacity**

Laws regulating decision-making in this space must be positioned with respect to scientific knowledge on adolescent cognitive, psychological, and neurobiological development and capacity to make medical decisions, as well as the context in which those decisions are made. It must be emphasised that treatment for trans youth is offered in the context of that young person individually requesting such treatment, and with such requests both having been preceded by a period of deep

59 *Bell Appeal* (n 53).

60 'Amendments to Service Specification for Gender Identity Development Service for Children and Adolescents', *NHS England* (Web Page, 2021) <<https://www.england.nhs.uk/wp-content/uploads/2020/12/amendment-to-cyp-gender-dysphoria-service-specification.pdf>>, archived at <<https://web.archive.org/web/20220114154031/http://www.england.nhs.uk/wp-content/uploads/2020/12/amendment-to-cyp-gender-dysphoria-service-specification.pdf>> ('Amendment to GIDS Specification 2021').

61 *Ibid.*

62 Butler et al (n 24) 634.

63 'Interim Service Specification for Specialist Gender Dysphoria Services for Children and Young People: Public Consultation', *NHS England* (Web Page, 4 December 2022) <<https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/>>. On the concerning aspects of this service specification, see 'AusPATH Statement about the Interim Service Specification for the Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers) by NHS England', *AusPATH* (Web Page, 16 November 2022) <<https://auspath.org.au/2022/11/16/auspath-statement-about-the-interim-service-specification-for-the-specialist-service-for-children-and-young-people-with-gender-dysphoria-phase-1-providers-by-nhs-england/>>.

64 See *Re G5* [2021] FCWA 228, [83] ('*Re G5*'); *Re G8* [2022] FCWA 66, [18] ('*Re G8*').

personal reflection, and being required to undergo patient, calm scrutiny through discussions with qualified practitioners. Trans youth are likely to have engaged in extensive independent research, deliberation, and decision-making prior to discussing their wishes about medical care with other people.<sup>65</sup> The young person finds themselves at the crux of a complex scenario. In lived experience, they are grappling daily with a health condition which involves major repercussions for dealing with physical and mental health, and their very identity as a person. In decisions to seek treatment, they are engaged in complex discussions and negotiations with parents, health systems, and legal systems. Developmentally, they are in the general phase of human development where cognitive understanding and decision-making capacity is rapidly approaching and indeed reaching that level understood as ‘adult-like’. For younger adolescents in this setting, the ages at which treatment is sought for puberty blockers and gender-affirming hormones occupy the earlier phases of adolescence, with diminishing dependence on parents; whereas older adolescents in this setting occupy a point further along the developmental spectrum of cognitive capacity in which competency to make health decisions is further developing and in many cases is fully formed.

These features of the context are important. Where an adolescent possesses sufficient decision-making competence, that competence ought to be respected to secure the individual’s autonomy and avoid an unjustifiable legal constraint on individual liberty. Both clinical practice and legal principles should be accurately informed by the scientific evidence of a developmental approach to adolescent capacity in decision-making. Where legal principle or clinical legal practice is inconsistent with this evidence, then they are in error.

In their authoritative 2019 review of developmental evidence in cognitive, psychosocial, and neurobiological domains, Steinberg and Icenogle emphasised that cognitive decision-making capacity in ‘cold’ settings — those allowing ‘unhurried deliberation in the absence of emotional arousal’ — is mature by age 16, underpinned by the attainment of the required cognitive capacity, and unaffected by the still-developing skills in self-regulation that can be influenced in ‘hot’ decision-making settings, which are made on the spur of the moment, especially when under the influence of peer pressure.<sup>66</sup> They concluded adolescents aged 16 years should therefore be legally recognised as having capacity to make decisions about matters reliant on cognitive processing in these situations, and insisted that policy-makers need to distinguish between these different types of decision-making contexts when determining the appropriate approach to age demarcations. Indeed, they expressly specified that settings in

65 Beth A Clark, Sheila K Marshall and Elizabeth M Saewyc, ‘Hormone Therapy Decision-Making Processes: Transgender Youth and Parents’ (2020) 79(1) *Journal of Adolescence* 136, 144.

66 Laurence Steinberg and Grace Icenogle, ‘Using Developmental Science to Distinguish Adolescents and Adults under the Law’ [2019] (1) *Annual Review of Developmental Psychology* 21, 34.

which this age threshold is appropriate include the decision to provide consent in medical and legal contexts.<sup>67</sup>

Moreover, this general conservative conclusion about all 16 year olds (save those in clearly different situations of cognitive capacity) does not rule out even younger children having sufficient cognitive capacity in such settings for diverse purposes. The 2019 review observed that two of the three analytical models reviewed in relation to cognitive capacity supported a general population demarcation point as age 15,<sup>68</sup> that many adolescents would reach this stage earlier than the age cut-off; and elsewhere, Steinberg has concluded cognitive capacity is attained substantially earlier than 16.<sup>69</sup>

Clark and Virani found, in their empirical study on the capacity and authority of trans youth to consent to hormone therapy in the Canadian province of British Columbia, that young people aged 14 to 18 demonstrated understanding and abilities characteristic of the capacity to make decisions about starting hormone therapy.<sup>70</sup> Youth, parents, and healthcare providers interviewed generally agreed that young people in that age range can possess the capacity to consent to that healthcare.<sup>71</sup> Most healthcare providers felt that the majority of youth who presented for care were well informed and had sufficient insight to consent to their own treatment. One healthcare provider noted that trans youth may be in a better position to consent than others their age due to their lived experience:

I actually find most of these kids that have had to ask this question to themselves are way more reflective than their peers of the same age, because they have had to look at questions that other youth may never have had to answer ... we see just a breadth of introspection and reflection that is well beyond their years.<sup>72</sup>

Accordingly, it is highly significant that from a developmental perspective, these decisions by trans youth are made in a ‘cold’ setting. In sum, two conclusions can be made from the developmental science: first, there is no impediment to conferring decision-making power on all adolescents aged 16, save in exceptional circumstances;<sup>73</sup> and second, those aged under 16 may well have sufficient

67 Ibid.

68 Ibid 33, citing Grace Icenogle et al, ‘Adolescents’ Cognitive Capacity Reaches Adult Levels Prior to Their Psychosocial Maturity: Evidence for a “Maturity Gap” in a Multinational, Cross-Sectional Sample’ (2019) 43(1) *Law and Human Behaviour* 69, 80.

69 See, eg, Dustin Albert and Laurence Steinberg, ‘Judgment and Decision Making in Adolescence’ (2011) 21(1) *Journal of Research on Adolescence* 211, 219. Steinberg’s work has also been affirmed in recent leading work on adolescence: see George C Patton et al, ‘Our Future: A Lancet Commission on Adolescent Health and Wellbeing’ (2016) 387(10036) *Lancet* 2423.

70 Beth A Clark and Alice Virani, “‘This Wasn’t a Split-Second Decision’”: An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy’ (2021) 18(1) *Journal of Bioethical Inquiry* 151, 162.

71 Ibid 159.

72 Ibid 155.

73 These could include situations in which the adolescent has an intellectual impairment such that they lack cognitive capacity to understand the nature of the proposed treatment.

cognitive capacity to make the decisions involved (especially those in relation to puberty blockers).

Clinical attitudes and policies regarding competence and consent, as well as legal requirements in respect of parental consent and adolescent competence, are central to accessing healthcare. As will be seen below, the extent to which the clinical and legal environment are congruent with developmental science can vary.

### III GENERAL LEGAL PRINCIPLES GOVERNING CONSENT BY MATURE YOUNG PEOPLE

Here, the general principles governing consent to medical treatment of children and young people are outlined and compared for both Australia, and England and Wales. This is essential context to situate the more specific case law which has concerned trans youth's gender-affirming medical treatment in the respective jurisdictions, which we will then synthesise.

Broadly, the legal principles governing consent to medical treatment for young people are very similar in Australia, and England and Wales. In both jurisdictions, a young person aged under 18 is generally considered to be a minor for most lawful purposes, and thus lacks automatic competence to make medical decisions, unless there is separate legislative or other authority to the contrary.<sup>74</sup> In England and Wales, and in Australia, there are principally three actors that may provide lawful consent to a child's medical procedure: persons with parental responsibility; a court; and a child, rendered competent by virtue of legislation or the common law.

There are key differences between the jurisdictions in respect of the position of those aged 16 years of age and older, as compared with young people below this age threshold. Legislation in one Australian state, South Australia, provides that children 16 years of age and over can consent to medical treatment 'as validly and effectively as an adult'.<sup>75</sup> However, the South Australian position is an outlier amongst Australian jurisdictions. In another Australian state, New South Wales,

74 *Children Act 1989* (UK) s 105(1); *Family Law Reform Act 1969* (UK) s 1 ('*Family Law Reform Act*'); *Age of Majority Act 1974* (ACT) s 5; *Minors (Property and Contracts) Act 1970* (NSW) s 9(1) ('*Minors (Property and Contracts) Act*'); *Age of Majority Act 1974* (NT) s 4; *Law Reform Act 1995* (Qld) s 17; *Age of Majority (Reduction) Act 1971* (SA) s 3; *Age of Majority Act 1973* (Tas) s 3; *Age of Majority Act 1977* (Vic) s 3(1); *Age of Majority Act 1972* (WA) s 5. Note, in New South Wales, s 49(2) of the *Minors (Property and Contracts) Act* (n 74) provides that consent given by children aged 14 years and over is recognised for the purposes of defending a claim of assault and battery. Note also that in Victoria, the *Medical Treatment Planning and Decisions Act 2016* (Vic) includes a statutory test for children's capacity to make decisions in relation to advance care planning of medical treatment: at s 4. See also Ben Mathews and Malcolm Smith, 'Children and Consent to Medical Treatment' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3<sup>rd</sup> ed, 2018) 159, 163–4. Note also, this list is not exhaustive of Australian territories. It is outside the scope of this article to consider the law relevant to territories external to mainland Australia, and to Jervis Bay.

75 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 3(a)(i), 4, 6 ('*Consent to Medical Treatment and Palliative Care Act*'). See also discussion below on codification of Gillick competence in that jurisdiction.

statute provides that consent given by children aged 14 years and over is recognised as akin to an adult for the purposes of defending a claim of assault and battery.<sup>76</sup> This provision has been subject to very little judicial consideration. It has been suggested, however, that this legislation is primarily concerned with immunity for medical practitioners from civil liability and likely does not create a general power of consent.<sup>77</sup> In England and Wales, the *Family Law Reform Act 1969* (UK) is similar to the legislation in South Australia, varying the situation for those aged 16 years and over, providing that the consent given by those individuals for surgical, medical, and dental treatment is as effective as if they were an adult.<sup>78</sup> Further, where a child of that age has given consent by virtue of that section, it shall not be necessary to obtain any consent from their parent or guardian.<sup>79</sup> In addition, the *Mental Capacity Act 2005* (UK), provides that ‘[a] person must be assumed to have capacity unless it is established that he lacks capacity’<sup>80</sup> and that ‘[a] lack of capacity cannot be established merely by reference to ... a person's age or appearance’.<sup>81</sup> These legislative provisions, read together, confer youth aged 16 or 17 in England and Wales the same status as adults for medical decisions where there is a presumption of capacity. In Australia, England, and Wales, where not granted competence at 16 years or 18 years by legislation, the common law gives colour to the situation of mature minors.<sup>82</sup>

It is widely accepted that minors in Australia, and in England and Wales, can lawfully consent to most medical treatments on their own behalf when they meet the requisite criteria for being deemed ‘Gillick competent’ under the common law.<sup>83</sup> *Gillick* competence is a concept derived from the House of Lords decision in *Gillick*, and was imported into Australian law by the Australian High Court decision in 1992 in *Secretary, Department of Health and Community Services v JWB* (‘*Marion’s Case*’).<sup>84</sup>

76 *Minors (Property and Contracts) Act* (n 74) s 49(2).

77 See New South Wales Law Reform Commission, *Young People and Consent to Health Care* (Report No 119, October 2008) 76–7.

78 *Family Law Reform Act* (n 74) s 8(1).

79 *Ibid.*

80 *Mental Capacity Act 2005* (UK) s 1(2) (‘*Mental Capacity Act*’).

81 *Ibid* s 2(3)(a).

82 Note that in South Australia, the legislation also provides guidance on situations where a child under the age of 16 may provide consent. A medical practitioner who is to administer medical treatment, can do so with the child’s consent when they are of the opinion: (1) that ‘the child is capable of understanding the nature, consequences and risks of the treatment’; and (2) ‘that the treatment is in the best interest of the child’s health and well-being’. The opinion of that medical practitioner must also be supported by ‘the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced’: *Consent to Medical Treatment and Palliative Care Act* (n 75) s 12(b)(i)–(ii). The South Australian position is an outlier amongst Australian jurisdictions.

83 Mathews and Smith (n 74) 186–95.

84 (1992) 175 CLR 218 (‘*Marion’s Case*’).

The *Gillick* case concerned the ability of doctors to lawfully prescribe contraceptive advice and treatment to girls under the age of 16 years without parental knowledge and consent.<sup>85</sup> The lawfulness of consent given by a minor under the age of 16 in the United Kingdom, the statutory age of capacity for medical decisions, had not yet been the subject of judicial consideration.<sup>86</sup> The House of Lords held that girls under the age of 16 could have legal capacity under the common law to give valid consent to the contraceptive advice and treatment, including medical examination.<sup>87</sup>

The circumstances in which such a girl could consent were given slightly different formulations by Lord Fraser and Lord Scarman.<sup>88</sup> Lord Fraser was of the view that a girl under the age of 16 could consent to contraceptive advice and treatment ‘provided she has sufficient understanding and intelligence to know what they involve’.<sup>89</sup> Lord Scarman, going one step further, held that parental rights to make medical treatment decisions for their child under the age of 16 terminate ‘if and when the child achieves a sufficient understanding and intelligence to enable him or her to *understand fully* what is proposed’.<sup>90</sup> Central to both of these formulations is that no fixed age is used as a reference point for lawful consent, a minor’s capacity to consent will be dependent on the facts of the particular case. Indeed, Lord Scarman went to lengths to expound the necessity of avoiding the rigidity of a fixed age rule, stating that

[i]f the law should impose upon the process of ‘growing up’ fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.<sup>91</sup>

In *Gillick*, their Lordships determined that offering contraceptive advice and treatment to girls under the age of 16 (in the circumstances outlined by Fraser and Scarman LJ) was permissible notwithstanding parental ignorance and lack of parental consent.<sup>92</sup> Lord Scarman held that ‘parental rights are derived from the parental duty and exist only so long as they are needed for the protection of the person and property of the child’.<sup>93</sup> Parental rights thus yield, over time, to the ability of the child capable of providing consent on their own behalf.<sup>94</sup>

85 *Gillick* (n 17) 120–1.

86 *Ibid* 123 (Parker LJ).

87 *Ibid* 169–70 (Lord Fraser), 188–90 (Lord Scarman), 194–5 (Lord Bridge). Note, this is only where the doctor has determined it is appropriate to offer the treatment.

88 Lord Bridge did not provide a formulation as his Lordship concurred with the opinions of Lord Fraser and Lord Scarman: *ibid* 194–5.

89 *Ibid* 169–70.

90 *Ibid* 188–9 (emphasis added).

91 *Ibid* 186.

92 *Ibid* 174–5 (Lord Fraser), 190–1 (Lord Scarman), 194–5 (Lord Bridge).

93 *Ibid* 183–4, 184.

94 *Ibid* 186 (Lord Scarman).



In Australia, before the 1992 High Court decision in *Marion's Case*, the situation for minors was similarly lacking in authoritative judicial guidance.<sup>95</sup> Devereux notes that, in the absence of Australian judicial pronouncements, the approach in Australia was one that reflected the (pre-*Gillick*) conservative English stance that parental consent was needed, despite there being no rigid rule that it was required, because there was no direct authority that the consent of a minor could be valid.<sup>96</sup> In *Marion's Case*, the question of whether a minor could consent to their own medical procedure was not directly relevant to the case stated before the High Court.<sup>97</sup> However, the Court deemed it important to consider the question of whether a child could consent, in law or in fact, before considering the ambit of parental consent which arose on the facts of the case.<sup>98</sup> That is, they deemed the question of whether a child could lawfully consent to their own treatment to be a 'threshold question'.<sup>99</sup> The majority of the High Court considered the *Gillick* case to be persuasive, that it 'accords with experience and with psychology', and thus 'should be followed in this country as part of the common law'.<sup>100</sup>

The Australian High Court emphasised the individualised nature of the *Gillick* competence test. That is, the Court accepted that capacity to consent is not obtained at a fixed age, depending, rather, on an assessment of the capacity and maturity of the individual child.<sup>101</sup> Their Honours noted that such a concept, for example, does not immediately presume that an intellectually disabled child is not competent; individual maturity and development is to be considered.<sup>102</sup> Although the discussion of *Gillick* competence in *Marion's Case* was in obiter, it has since been directly applied in other cases.<sup>103</sup>

The *Gillick* decision concerned consent by young girls to the contraceptive pill, however its potential reach extends to almost all medical decisions by mature minors. The principle of *Gillick* competence is ordinarily not controversial and is embedded in routine clinical practice in Australia and in England and Wales. Indeed, it was codified in South Australian legislation for those under the age of 16. There, a medical practitioner can administer medical treatment with the child's consent when they, and another medical practitioner, are of the opinion that: (1) 'the child is capable of understanding the nature, consequences and risks of the

95 See generally John Devereux, 'The Capacity of a Child in Australia to Consent to Medical Treatment: *Gillick* Revisited?' (1991) 11(2) *Oxford Journal of Legal Studies* 283.

96 Ibid 285.

97 The stated case was set out in the judgement of Mason CJ, Dawson, Toohey and Gaudron JJ: *Marion's Case* (n 84) 229–30.

98 Ibid 236–9.

99 Ibid 236.

100 Ibid 237–8.

101 Ibid.

102 Ibid 239.

103 See, eg, *Re Jamie* (2013) 278 FLR 155 ('*Re Jamie*').

treatment’; and (2) ‘that the treatment is in the best interest of the child’s health and well-being’.<sup>104</sup>

A great deal of deliberation on the application of *Gillick* has involved situations where a young person has refused treatment, especially in life-threatening circumstances. There are fewer contexts in which a young person’s provision of consent to a medical procedure is contentious. However, it has invited considerable scrutiny and debate in the context of trans youth seeking gender-affirming medical treatment in both Australia and in England and Wales.

## IV CASE LAW ON CONSENT FOR TREATMENT BY TRANS YOUTH

General principles concerning consent to children’s medical treatment have received judicial attention in a growing body of cases, both in Australia and in England and Wales, that focus specifically on healthcare for trans youth. A brief review of the relevant case law that concern consent to treatment for trans youth in Australia and in England and Wales is provided here, before examining the contours of the law that those decisions shaped.

### A Australia

#### 1 *Re Alex (2004)*

Consent for treatment for trans youth with gender dysphoria first attracted differential treatment under Australian law in the 2004 Family Court case of *Re Alex*.<sup>105</sup> The child, with the pseudonym ‘Alex’, was 13 years old, assigned female at birth, though identified as male. Alex was clinically diagnosed with gender identity disorder under *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (‘*DSM-IV*’)<sup>106</sup> and wished to undergo treatment to halt menstruation (the contraceptive pill) and then later take puberty blockers and testosterone to masculinise his body.<sup>107</sup> Chief Justice Nicholson first considered whether Alex could give consent to the treatment himself and, secondly, whether the treatment proposed was a special medical procedure to which parents and guardians could not consent.<sup>108</sup>

Chief Justice Nicholson did not consider the evidence to establish Alex as having the capacity to consent to the proposed treatment according to the *Gillick*

104 *Consent to Medical Treatment and Palliative Care Act* (n 75) s 12(b)(i).

105 (2004) 180 FLR 89, 121 [180] (‘*Re Alex*’).

106 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (4<sup>th</sup> ed, 1994) 532–8.

107 *Ibid* 106–7 [98]–[99].

108 *Ibid* 116 [152].

standard.<sup>109</sup> *Gillick*, imported into Australia by the High Court in *Marion's Case*, allows a minor to give lawful consent when they achieve 'sufficient understanding and intelligence to enable him or her to *understand fully* what is proposed.'<sup>110</sup> Chief Justice Nicholson went on to say that he thought it 'highly questionable whether a 13 year old could ever be regarded as having the capacity for [consenting to treatment for gender identity disorder] ... and this situation may well continue until the young person reaches maturity'.<sup>111</sup> In any case, his Honour considered it to be an 'academic question' given that he was likely to rule the treatment to be in Alex's best interests and authorise on that basis.<sup>112</sup>

After declining to address the issue of *Gillick* competency, Nicholson CJ then moved on to consider whether the nature of the treatment, when viewed through the lens of the principles in *Marion's Case* was a 'special medical procedure' which necessitated that the court authorise the procedure, rather than the applicant give consent as Alex's legal guardian.<sup>113</sup> Special medical procedures, a legal category of medical treatments first articulated in the High Court decision of *Marion's Case*, are those which fall outside the bounds of medical treatments parents can consent to and require court approval.<sup>114</sup> Chief Justice Nicholson summarised the principles in *Marion's Case* to the effect that a special medical procedure is so-called where if a young person could not consent to the procedure, parental consent would be ineffective where the procedure is: (1) 'invasive, permanent and irreversible'; and (2) 'not for the purpose of curing a malfunction or disease'.<sup>115</sup>

Applying the first principle, Nicholson CJ accepted the evidence before the Court that though the first stage of treatment (contraceptive pill) was reversible, the second (puberty blockers and gender-affirming hormones) was not.<sup>116</sup> His Honour accepted that he should treat both stages of the treatment as a single treatment plan; the implication being that the treatment plan was, as a whole, irreversible.<sup>117</sup> Applying the second principle, Nicholson CJ looked at whether the treatment was therapeutic, being the treatment of physiological conditions, namely, disease or malfunction in organs.<sup>118</sup> Chief Justice Nicholson noted that no specific submissions were made as to this question.<sup>119</sup> However, his Honour questioned the

109 Ibid 118 [168].

110 *Gillick* (n 17) 188–9 (Lord Scarman) (emphasis added).

111 *Re Alex* (n 105) 120 [173].

112 Ibid 119 [169].

113 Ibid 120 [174].

114 *Marion's Case* (n 84) 236–7.

115 Ibid 116 [153].

116 Ibid 122 [181], [183].

117 Ibid 122–3 [188].

118 Ibid 124 [195].

119 Ibid 123 [191].

medical experts that gave evidence on the proposed treatment.<sup>120</sup> Their view was that medical science could not definitively show ‘gender identity dysphoria’ to be of biological origins.<sup>121</sup> This contrasted with a finding of the Full Court one year earlier in *Attorney-General (Cth) v ‘Kevin and Jennifer’*.<sup>122</sup> Nevertheless, Nicholson CJ was of the view that the proposed treatment could not be said to cure a disease or correct some physiological malfunction, and therefore was non-therapeutic.<sup>123</sup> His Honour also noted that ‘[t]here are significant risks attendant to embarking on a process that will alter a child or young person who presents as physically of one sex in the direction of the opposite sex’.<sup>124</sup> On that basis, Nicholson CJ, in 2004, found that gender-affirming treatment, including puberty blockers and gender-affirming hormones, was a special medical procedure that required court authorisation.

*Re Alex* influenced jurisprudence over many years concerning the extent to which treatment for a trans young person, in the form of puberty blockers, gender-affirming hormones, and surgical interventions, constituted a special medical procedure. At various points in time, based upon judicial assessments of medical evidence regarding treatment for trans youth, court approval has been required for puberty blockers, gender-affirming hormones, and chest surgery for minors with gender dysphoria, based upon the *Re Alex* judgement and special medical procedure principles.<sup>125</sup> The principles mandate court approval for treatments which are ‘non-therapeutic’ and have a combination of other risk factors, such as major, irreversible effects and where there may be a conflict of interest in decision-making, such as between parents and children.<sup>126</sup> The extent to which these principles have been properly interpreted and applied by Family Court judges is questionable.<sup>127</sup> While much of this body of law has concerned the metes and bounds of parental consent, another focus has been on the application of *Gillick* in terms of trans youth consenting to their own treatment.

120 Ibid 123–4 [193]–[194].

121 Ibid 123–4 [192]–[194].

122 (2003) 172 FLR 300. This case concerned a trans adult, where it was held that the incongruence between the gender the individual’s brain recognised them to be and their physiological indicia was ‘probably of biological origin’: at 311 [56].

123 *Re Alex* (n 105) 124 [195]–[196].

124 Ibid 124 [196].

125 See, eg, *Re Brodie (Special Medical Procedure)* [2008] FamCA 334; *Re Bernadette (Special Medical Procedure)* (2010) 244 FLR 242; *Re O (Special Medical Procedure)* [2010] FamCA 1153; *Re Sean and Russell (Special Medical Procedures)* (2010) 258 FLR 192; *Re Rosie (Special Medical Procedure)* (2011) FamCA 63; *Re Jodie* [2013] FamCA 62; *Re Lucy (Gender Dysphoria)* (2013) 286 FLR 327 (‘*Re Lucy*’); *Re Sam and Terry (Gender Dysphoria)* (2013) 49 Fam LR 417.

126 It must be noted here that a major flaw of this jurisprudence has been the conclusion by judges that treatment for gender dysphoria is non-therapeutic, an error which has been corrected in later judgements.

127 See Bell (n 3).

## 2 Re Jamie (2013)

In 2013, the case of *Re Jamie* changed the legal landscape considerably.<sup>128</sup> Jamie was a child of nearly 11 years old seeking treatment for gender identity disorder in the form of pubertal suppressants and oestrogen to encourage feminine pubertal development. The major contribution of the *Re Jamie* decision was that, despite not being able to conclusively determine the cause of diverse gender identity, treatment was found to be therapeutic, as gender dysphoria is a recognised condition in the *DSM-5*.<sup>129</sup>

The Full Court of the Family Court ruled that puberty blockers (stage 1 treatment), being therapeutic and reversible, could no longer be seen as a special medical procedure,<sup>130</sup> and accordingly parents could give lawful consent to that treatment. In relation to gender-affirming hormone treatment (stage 2 treatment), however, the Court ruled that either court approval or court assessment of *Gillick* competency was required due to the irreversible changes brought about by gender-affirming hormones and greater risks attending such interventions.<sup>131</sup> Judicial assessment of *Gillick* competence had never been required for any other type of medical procedure or treatment as a general rule; judicial competence assessments arising only in individual cases of a young person's refusal of treatment. The judgement represented the introduction of a unique requirement for trans and gender diverse youth: *Gillick* competency assessments ordinarily residing in the hands of treating doctors.

Following that judgement, many applications to the Family Court concerned approval of treatment or competence assessments for trans young people where the judiciary *always* accepted medical advice from treating doctors on the child's competency.<sup>132</sup> Such an exercise could be viewed as futile given that courts agreed with medical professionals on every occasion. A more sceptical view is that the gatekeeping function operates such that only young people with access to appropriate resources and support are able to navigate this process at all. That process was required in all cases until the 2017 decision of the Full Court of the Family Court in *Re Kelvin*.<sup>133</sup>

## 3 Re Kelvin (2017)

In *Re Kelvin*, the Full Court revisited key questions of law in this area through a case stated to them from Watts J. They determined that where a doctor assessed an adolescent as *Gillick* competent, and doctors, parents, and the child were in

128 *Re Jamie* (n 103).

129 *Ibid* 175 [91], 177 [97] (Bryant CJ), 190 [176] (Finn J), 193 [193] (Strickland J).

130 *Ibid* 177 [98] (Bryant CJ).

131 *Ibid* 184 [140] (Bryant CJ), 192 [188] (Finn J), 193 [195] (Strickland J).

132 See, eg, *Re Spencer* [2014] FamCA 310; *Re Martin* (n 5); *Re Jacinta* [2015] FamCA 1196. See also *Re Logan* [2016] FamCA 87, [7].

133 (2017) 327 FLR 15 ('*Re Kelvin*').

agreement, gender-affirming hormone treatment could proceed without routine court oversight of the competency assessment.<sup>134</sup> They also determined that parents could consent to that treatment without the need for court approval.<sup>135</sup> In their opinion, changes in medical evidence lessened the risk of wrong decisions being made in those circumstances.<sup>136</sup> While the Full Court judgement was explicitly confined to stage 2 treatment (gender-affirming hormones), the courts have generally equated the law in respect of stage 2 treatment with the law in respect of stage 3 surgery.<sup>137</sup>

In reaching this view, the central consideration was whether the existing law was ‘able to effectively reflect the current state of medical knowledge’.<sup>138</sup> The majority found that it was ‘readily apparent that the judicial understanding of Gender Dysphoria and its treatment ... [had] fallen behind the advances in medical science’.<sup>139</sup> Advances in medical science they held significant included: the revisions of the diagnosis between *DSM-IV* and *DSM-5*; development of Australian-specific standards of care and treatment guidelines; evidence of outcomes of those treated at the Melbourne paediatric gender clinic and increased knowledge regarding the risks of non-treatment. These developments were said to render it beyond dispute that ‘the state of medical knowledge has evolved since the decision in *Re Jamie*’.<sup>140</sup> Accordingly, the majority held that gender-affirming hormone treatment for gender dysphoria ‘can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court’.<sup>141</sup> However, of importance to later judgements, the majority noted that their ruling did not address the need for court authorisation where there is a ‘genuine dispute or controversy’ as to whether treatment should be administered.<sup>142</sup> Because of the framing of the stated case, it was unclear from *Re Kelvin* what the legal principles were in respect of *Gillick*-competent young people with one or more unsupportive parents.

134 Ibid 44 [177], [182] (Thackray, Strickland and Murphy JJ).

135 Ibid 50 [213].

136 Ibid 41–2.

137 See *Re Mathew* [2018] FamCA 161, [46] (*‘Re Mathew’*). But see *Re LG* [2017] FCWA 179, [14] (*‘Re LG’*).

138 *Re Kelvin* (n 132) 40 [152] (Thackray, Strickland and Murphy JJ).

139 Ibid.

140 Ibid 41 [159].

141 Ibid 42 [164].

142 Ibid 42 [167]. The Court in *Re Kelvin* (n 132) also did not address the law in respect of children who are in the care of the State or the legal principles for surgical interventions to affirm gender which may be sought in adolescence. The latter judgement of *Re Mathew* (n 137) extended the *Re Kelvin* principles to surgical treatment so that the law is the same as that for gender-affirming hormones: *Re Mathew* (n 137) [45]–[47]. *Re Chloe* [2018] FamCA 1006 extended *Re Kelvin* to those in care, with the responsibilities of State Government Minister in that case found to be broader than parents and sufficient to provide consent: at [24]–[26].

#### 4 Re Imogen (2020)

In 2020, in *Re Imogen*, a single judge of the Family Court clarified the legal principles in respect of trans young people where one or both parents may not be wholly supportive of treatment.<sup>143</sup> In that case, Watts J ruled that medical practitioners cannot lawfully proceed to administer treatment without consent from both parents, for puberty blockers, gender-affirming hormones, or surgical interventions, even where an adolescent is assessed by doctors as being *Gillick* competent.<sup>144</sup> His Honour held that a court application is *always* required where *both* parents do not provide consent for treatment. Moreover, Watts J held that a court application is mandatory where a parent or a medical practitioner of an adolescent disputes the *Gillick* competence of an adolescent, or their diagnosis of gender dysphoria, or the proposed treatment for gender dysphoria.<sup>145</sup> Depending upon which of those aspects are in dispute, the court may undertake a competency assessment of the adolescent, a best interests assessment, or both.<sup>146</sup>

Accordingly, as a result of *Re Imogen*, in Australian states that rely upon the common law, where an adolescent is assessed as *Gillick* competent, they may provide consent for their own gender-affirming hormones or surgery, where both parents also provide consent, and they are in agreement with the treating doctors. Notably, this would not apply in the state of South Australia where the consent principles are derived from legislation rather than the common law.

*Re Imogen* clarified ambiguity in the law around dispute and controversy; albeit in a concerning way. Given that the law laid out by Watts J appears to contradict a common-sense application of *Gillick* and introduces a requirement for dual parental consent that is not found elsewhere, it is expected that future case law will address these issues. The ruling in *Re Imogen* is of a single judge of the Family Court, rather than the Full Court, and lacks binding force. It is therefore open to another judge of the Family Court to rule differently and, indeed, a judge of the Queensland Supreme Court has.

#### 5 Re A (2022)

In 2022, the case of *Re A* came before the Queensland Supreme Court.<sup>147</sup> The case was notable in that it was brought pursuant to the Court's *parens patriae* jurisdiction rather than the statutory welfare jurisdiction of the Family Court; the forum in the overwhelming majority of cases concerning gender-affirming medical treatment of young people.<sup>148</sup> The case was brought in response to the *Re Imogen* requirement

143 *Re Imogen [No 6]* (2020) Fam LR 344 ('*Re Imogen*').

144 *Ibid* 357 [63].

145 *Ibid* 351 [35].

146 *Ibid* 356 [59].

147 (2022) 11 QR 1 ('*Re A*').

148 For another case which also came before the QSC following *Re Imogen* (n 143), see *Re a Declaration regarding Medical Treatment for A* (2020) 6 QR 718.

for both parents' consent, with the mother seeking an urgent order for stage 2 treatment in circumstances where the father was opposed.

The approach in *Re A* differed considerably from that in *Re Imogen*. Justice Boddice was critical of the statements in both *Re Jamie* and *Re Imogen* regarding the impact of controversy or dispute on *Gillick* competence. His Honour opined that

if the child is *Gillick* competent, then subject to some obiter dicta in ... [*Re Jamie*], that really should be the end of the matter. It is then a situation where the child, if giving consent to that treatment, is to receive the treatment notwithstanding the views of one or more of the child's parents.<sup>149</sup>

Once it is concluded that the child is *Gillick* competent, the question must be asked why it is that a child who is almost 17 years of age, is *Gillick* competent and is firm in the view of what treatment they would like, should be denied the opportunity to do so without the consent of both parents. Such a conclusion would be inconsistent with the human rights of the child and a recognition of the importance of *Gillick* competence and its effect as a matter of law.<sup>150</sup>

For those reasons, his Honour was prepared to rule that *Re Jamie* and *Re Imogen* wrongly stated the law and decline to follow them on that basis. However, as the conclusions stated by the Full Court in *Re Jamie* were merely obiter dicta, this was deemed unnecessary.<sup>151</sup>

Justice Boddice did not examine the medical evidence in detail and did not focus on the disputing parents' views. His Honour's conclusion that the young person was *Gillick* competent provided a sufficient basis for a declaration of such, enabling medical practitioners to validly and lawfully act upon the young person's consent. At the time of writing, no cases before state supreme courts or the Family Court have dealt with the differing views of Watts J and Boddice J, leaving the Australian legal principles uncertain in respect of parental dispute or non-involvement.

## **B England and Wales**

### **1 PD v SD (2015)**

In England and Wales, medical treatment for trans youth with gender dysphoria first came before a court in the 2015 case of *PD v SD*.<sup>152</sup> There, a trans young person was granted privacy and confidentiality in respect of possible treatment of his gender dysphoria.<sup>153</sup> P, who was 16 years old, had attended an appointment at

149 *Re A* (n 147) 5 [15].

150 *Ibid* 6 [24].

151 *Ibid* 6 [27].

152 *PD v SD* [2015] EWHC 4103 (Fam), [4] ('*PD v SD*').

153 *Ibid*.



the GIDS at the Tavistock, and anticipated receiving treatment from the clinic. P's parents were not wholly supportive of his gender identity and related possible treatment. Following hospitalisation after an overdose, P had been placed in foster care and was later made a ward of the court.<sup>154</sup> P sought a declaration that, in effect, would preclude his parents from involvement in his life, including from access to any information regarding his assessment and possible treatment at the Tavistock or other medical facility.<sup>155</sup>

Justice Keehan noted that P, being 16 years old, could give valid consent to medical and surgical treatment in accordance with s 8 of the *Family Law Reform Act 1987* (UK).<sup>156</sup> The issue regarding whether his parents would be involved or informed about his medical care was enlivened by the child protection legislation, as the local authority was obliged to consult with and give information to parents of children in their care.<sup>157</sup> Justice Keehan found the issue engaged art 8 rights to 'private and family life, his home and his correspondence' under the *European Convention on Human Rights*,<sup>158</sup> and that the rights of P and his parents were, in respect of art 8, in opposition. His Honour took particular account of a decision of the European Court of Human Rights that provided that where such a tension exists, the right of the child should prevail.<sup>159</sup> His Honour quoted a passage from Lord Scarman's judgement in *Gillick*, where his Lordship asserted that the rights of parents exist primarily so that they may discharge duties towards children until such time that they are capable of looking after themselves.<sup>160</sup> Further, he quoted with approval, Silber J's judgement in *R (Axon) v Secretary of State for Health*, where his Honour said:

Parental right to family life does not continue after the time when the child is able to make his own decisions. So parents do not have Article 8 rights to be notified of any advice of the medical profession after the young person is able to look after himself or herself and make his or her own decisions.<sup>161</sup>

On the basis of those authorities, Keehan J concluded that P's decision to exclude his parents from his day-to-day life and medical care at the Tavistock was 'a decision he is perfectly entitled to reach and is one which this court must respect'.<sup>162</sup> In balancing P's rights with those of his parents, 'the balance falls

154 Ibid [1]–[5].

155 Ibid [6].

156 Ibid [20].

157 Ibid [21]–[22].

158 *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) art 8.

159 *PD v SD* (n 152) [23], citing *Yousef v Netherlands* (European Court of Human Rights, Chamber, Application No 33711/96, 5 February 2003) [73].

160 *PD v SD* (n 152) [26], quoting *Gillick* (n 17) 185.

161 *PD v SD* (n 152) [28]–[29], quoting *R (Axon) v Secretary of State for Health* [2006] QB 539, 150–1 [132] (Silber J).

162 *PD v SD* (n 152) [31]–[32].

decisively in favour of P's Article 8 rights'<sup>163</sup> and Keehan J granted P the declaratory relief he sought.<sup>164</sup> There was no suggestion that P's power to consent on his own behalf, or to exclude his parents from his medical care for gender dysphoria, was any different from the exercise of that right in other contexts. It was implicitly accepted that decisions about hormonal treatment for gender dysphoria were within the scope of decisions a young person is entitled to make, if they have capacity under s 8 of the *Family Law Reform Act 1987* (UK).<sup>165</sup> Further, it confirmed that which seems, on its face, logical; namely, that where a young person is competent to consent to their own medical care by virtue of the legislation, parental opposition to treatment is rendered immaterial.

## 2 Bell (*Divisional Court*) (2020)

In the 2020 decision of *Bell*, the High Court of England and Wales (Divisional Court) addressed the issue of consent for the provision of puberty blockers to trans youth with gender dysphoria.<sup>166</sup> Judicial review was sought by Bell, a former patient of the GIDS at the Tavistock, and Mrs A, the mother of a child with autism spectrum disorder, regarding the practice of the Tavistock through their GIDS.<sup>167</sup> Two of the intervenors comprised the hospital trusts in London and Leeds that prescribed pubertal-suppressants to patients under the age of 18 with gender dysphoria.<sup>168</sup> The claimants' argument was that young people under the age of 18 are not competent to give consent to puberty blockers, that information provided by the Tavistock to inform that consent is misleading and insufficient and that, as a result, there was an infringement of children's rights under the *European Convention for the Protection of Human Rights and Fundamental Freedoms*.<sup>169</sup> In respect of these arguments, the Divisional Court recognised that a *Gillick* competent child could give consent to treatment based upon the information provided by the Tavistock. They emphasised the individualised nature of the *Gillick* test:

[T]he question as to whether a person under the age of 16 is *Gillick* competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person's individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information ...<sup>170</sup>

163 Ibid [35].

164 Ibid [36].

165 Strangely, this case was not referred to or relied upon in later jurisprudence on this issue. See also Smith (n 16) 19.

166 *Bell Divisional Court* (n 12).

167 Ibid [2].

168 Ibid.

169 Ibid [7], citing *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) art 8.

170 *Bell Divisional Court* (n 12) [126].

Further, they said that there is an onus on the doctors to help young people achieve competency:

[E]fforts should be made to allow the child or young person to achieve *Gillick* competency where that is possible. Clinicians should therefore work with the individual to help them understand the treatment proposed and its potential implications in order to help them achieve competence.<sup>171</sup>

They noted, however:

[T]hat does not mean that every individual under 16 can achieve *Gillick* competence in relation to the treatment proposed ... where the consequences of the treatment are profound, the benefits unclear and the long-term consequences to a material degree unknown, it may be that *Gillick* competence cannot be achieved, however much information and supportive discussion is undertaken.<sup>172</sup>

The Divisional Court set out what needed to be understood to be able to consent to puberty blockers:

It follows that to achieve *Gillick* competence the child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.<sup>173</sup>

Of these factors, it was the ‘highly complex and potentially lifelong and life changing’ issues around fertility and sexual function which most concerned the Court:

Although a child may understand the concept of the loss of fertility for example, this is not the same as understanding how this will affect their adult life. A child’s attitude to having biological children and their understanding of what this really means, is likely to change between childhood and adulthood. For many children, certainly younger children, and some as young as 10 and just entering puberty, it will not be possible to conceptualise what not being able to give birth to children (or conceive children with their own sperm) would mean in adult life. Similarly, the meaning of

171 Ibid [128].

172 Ibid [129].

173 Ibid [138].

sexual fulfilment, and what the implications of treatment may be for this in the future, will be impossible for many children to comprehend.<sup>174</sup>

The Court acknowledged the submission that ‘many decisions about complex and long-lasting medical treatment will involve the patient having, to some degree, to imagine themselves into an uncertain future of which they have no experience’.<sup>175</sup> In their view, treatment for gender dysphoria is ‘different in kind to other treatments or clinical interventions’ because it does not have a physical manifestation but treatment for it induces physical changes and the effects are not direct and apparent.<sup>176</sup> Accordingly, they were of the view that due to the difficulty of weighing up the aforementioned information, medical treatment for trans youth is an ‘entirely different territory from the type of medical treatment which is normally being considered’.<sup>177</sup>

Ultimately, the Court gave guidance as to whether a young person could be found *Gillick* competent to consent to puberty blockers, based upon their age. The Court also gave guidance on the application of *Gillick* to particular age brackets, relying on testimony from Professor Scott, Director of University College London’s Institute of Cognitive Neuroscience. Professor Scott had sought

to explain, from a neuroscientific point of view, why [he has] significant doubts about the ability of young people under the age of 18 years old to adequately weigh and appreciate the significant consequences that will result from the decision to accept hormonal treatment for gender dysphoria.<sup>178</sup>

As the Court acknowledged, Professor Scott

explained the neurological development of adolescents’ brains that leads to teenagers making different, more risky decisions than adults. She said further that this is backed up by behavioural studies showing that when decision making is ‘hot’ (ie more emotional), under 18 year olds make less rational decisions than when the responses are made in a colder, less emotional context. Her conclusion was that

11. ... given the risk of puberty blocking treatment, and the fact that these will have irreversible effects, that have life-long consequences, it is my view that even if the risks are well explained, that in the light of the scientific literature, that it is very possible for an adolescent to be unable to fully grasp the implications of puberty-blocking treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behaviour.<sup>179</sup>

174 Ibid [139].

175 Ibid [139].

176 Ibid [135].

177 Ibid [140].

178 Ibid [45].

179 Ibid [46].

The Court did not itself refer to any of the scientific evidence about development and decision-making capacity. Nor did it subject Professor Scott's description of the evidence to any critical scrutiny. The Court simply uncritically accepted this representation of the science, and in applying this to children aged 13 and under, the Court held that '[i]t is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers.'<sup>180</sup> For those aged 14 or 15, the Court viewed it as 'doubtful' that they 'could understand and weigh the long-term risks and consequences of the administration of puberty blockers'.<sup>181</sup> Regarding those aged 16 and over, the Court acknowledged that the legislation provided that 'there is a presumption that they have the ability to consent to medical treatment'.<sup>182</sup> Nevertheless, the Court was of the view that

[g]iven the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, [it] recognise[s] that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.<sup>183</sup>

The Divisional Court in *Bell* indicated they were unwilling to mandate routine court involvement in cases where trans youth were seeking treatment. They provided that they '[did] not consider that the court can somehow adopt an intrusive jurisdiction in relation to one form of clinical intervention for which no clear legal basis has been established'.<sup>184</sup> Despite this apparent reluctance, the Divisional Court indicated that given the nature of treatment, clinicians might find court involvement desirable.

### **3 AB v CD (2021)**

In the 2021 case of *AB v CD*,<sup>185</sup> a mother of a child (XY) applied for a declaration that she and the child's father could provide lawful consent on behalf of XY to puberty blockers. Broadly, the judgement considered whether persons with parental responsibility in England and Wales can provide consent to puberty blockers for their child, or whether the decision should be brought to court arising out of legal requirement or 'good practice'. It also addressed whether parental ability to consent existed concurrently with that of the *Gillick* competent young person.

The Divisional Court had not considered the law regarding parental consent in *Bell* as the GIDS clinic had indicated then that they would not accept proxy consent. The evidence put forth by the GIDS in *AB v CD*, however, was that they would still refer a young person for hormonal treatment where the young person wished

180 Ibid [151].

181 Ibid.

182 Ibid [152].

183 Ibid.

184 Ibid [146].

185 *AB v CD* (n 13).

to be referred and they understood the nature of the referral, even if such understanding did not meet the bar for *Gillick* competence set out in *Bell*, in circumstances where the young person's parent was supportive and where there was agreement and recommendation for treatment from the GIDS clinicians working with the child.<sup>186</sup> Justice Lieven proceeded to address these question while acknowledging she was bound by the *Bell* judgement, thus her judgement was not 'intended to depart, to even the smallest extent, from anything that was said in *Bell*'.<sup>187</sup>

Prior to the *Bell* decision, XY had been clinically assessed as *Gillick* competent and commenced taking pubertal blockers, yet had not been re-assessed in light of the legal guidance given by the Court there. It was put to the Court that, after the *Bell* decision, some GPs were continuing to prescribe puberty blockers but that many were choosing not to. It was unclear whose consent could be relied upon by a clinician in prescribing to XY going forward. It was the unanimous view of XY, her parents and clinicians that she should continue on puberty blockers. Justice Lieven noted that clarity for medical practitioners on the lawfulness of parental consent in this context was needed.

The first question the court addressed was whether persons with parental responsibility have a continuing legal ability to consent concurrently with their child deemed *Gillick*-competent. Justice Lieven held that 'parents' right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child'.<sup>188</sup> Accordingly, XY's parents retained parental authority to consent to treatment regardless of whether XY was *Gillick* competent to make that decision themselves.<sup>189</sup>

The second question was whether puberty blockers fell into a 'special category' of medical treatment which *required* a court application or whether such an application should come before a court as a matter of 'good practice'.<sup>190</sup> Justice Lieven noted that, aside from the 'exceptional' case of *Re D* involving the non-therapeutic sterilisation of a minor, the court has not imposed a mandatory nor best practice requirement to come to court for a child's medical treatment, 'including where the parental decision will lead to the child's life ending'.<sup>191</sup> Justice Lieven was not in favour of a legal rule of blanket application to consent to puberty blockers. Her Honour noted the long line of cases in which judges have 'urged against general rules that classes of case had to come to Court where the individual facts did not justify that approach'.<sup>192</sup> Accordingly, Lieven J concluded that she

186 Ibid [30].

187 Ibid [9].

188 Ibid [114].

189 Ibid [69].

190 Ibid [71].

191 Ibid [116], discussing *Re D (A Minor)* [1976] Fam 185.

192 Ibid [98].

did not consider that puberty blockers to treat gender dysphoria ‘should be placed in a special category by which parents are unable in law to give consent’.<sup>193</sup> However, her Honour noted that ‘if the clinicians consider the case to be finely balanced, or there is disagreement between the clinicians, then the case should be brought to Court’.<sup>194</sup>

#### 4 Bell (Court of Appeal) (2021)

In 2021, the Court of Appeal heard an appeal by the Tavistock against the decision of the Divisional Court in *Bell*. The Court of Appeal was asked to consider ‘whether the Divisional Court, not having held that Tavistock’s ... policies and practices were unlawful, was right to make the declaration and give the guidance it did’.<sup>195</sup>

The Court of Appeal held that the declaration made by the Divisional Court ‘covered areas of disputed fact, expert evidence and medical opinion’, which were not suitable for determination in judicial review proceedings.<sup>196</sup> In particular, the Court of Appeal was critical of the Divisional Court’s guidance to clinicians regarding *Gillick* competence. They did not support the routine involvement of judges in assessing the competence of trans youth, noting that

it is for the clinicians to exercise their judgement knowing how important it is that consent is properly obtained according to the particular individual circumstances, as envisaged by *Gillick* itself, and by reference to developing understanding in this difficult and controversial area.<sup>197</sup>

The Court clarified that ‘[t]he *ratio decidendi* of *Gillick* was that it was for doctors and not judges to decide on the capacity of a person under 16 to consent to medical treatment’.<sup>198</sup> They were also critical of the age-based categories in the Divisional Court’s guidance to clinicians.<sup>199</sup> The Court rejected an exceptionalism argument regarding the application of *Gillick* to gender-affirming medical treatment:

Nothing about the nature or implications of the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in *Gillick* and of puberty blockers in this case bearing in mind that, when *Gillick* was decided 35 years ago, the issues it raised in respect of contraception for the under 16s were highly controversial in a way that is now hard to imagine.<sup>200</sup>

193 Ibid [128].

194 Ibid.

195 *Bell Appeal* (n 53) [59].

196 Ibid [72].

197 Ibid [93].

198 Ibid [76].

199 Ibid [94].

200 Ibid [76].

Ultimately, the Court of Appeal held that the Divisional Court imposed an ‘improper restriction on the *Gillick* test of competence ... through the terms of the declaration itself, by the utilisation of age criteria and by the requirement to make applications to the court’.<sup>201</sup> However, the Court of Appeal still noted a limited role for the Court in ‘specific difficult cases’ while declining to give guidance as to when such circumstances might arise.<sup>202</sup>

The practical effect of the Court of Appeal’s decision was immense, with the NHS responding to alter their consent processes for the GIDS accordingly.<sup>203</sup> It is notable that while the Australian case law continues to paint gender-affirming treatment with a ‘special’ brush, the *Bell* appeal judgement effectively cements the position that the law applying to gender-affirming treatment is the same as applies to other forms of medical treatment for young people in England and Wales. This critical difference is explored further in the comparative analysis that follows.

## V COMPARATIVE ANALYSIS

The following section provides a comparative analysis of the similarities and differences between the jurisdictions, considering the extent to which they impede gender-affirming care for trans youth and resulting practical implications.

### A *Is There a Requirement for Court Approval of Treatment?*

Australia’s requirement for court application in all cases of trans youth seeking gender-affirming treatment has been whittled down over the last two decades. Earlier judgements considered puberty blockers, gender-affirming hormones, and surgery to require court oversight of parental consent based upon special medical procedure principles. Australian legal principles have developed to reflect contemporary society and science, albeit slowly. Following *Re Kelvin* and *Re Imogen*, there is still a role for the court, but only for *some* trans youth. The subsequent decision of *Re A* casts these requirements into doubt, suggesting the remaining role of courts may be even more narrow. Without a judgement resolving this conflict, or legislative intervention, the circumstances in which court oversight is required is unclear. Clinicians outside the states of South Australia, where they have legislation, and Queensland, where *Re A* was decided, are likely to be complying with *Re Imogen* requirements.

The *Re Imogen* requirement to approach the court now only exists where *both* parents do not consent, or where a parent disputes *Gillick* competency, diagnosis, and treatment.<sup>204</sup> Court involvement is required in those circumstances even where

201 Ibid [94].

202 Ibid. Note that leave to appeal this decision to the Supreme Court was refused: *R (Bell) v Tavistock and Portman NHS Foundation Trust* [2022] PTSR 931.

203 See ‘Amendment to GIDS Specification 2021’ (n 60).

204 *Re Imogen* (n 143) 351 [35].



a young person is clinically assessed as *Gillick* competent. Depending upon which of those aspects are in dispute, the court may undertake a competency assessment of the adolescent, a best interests assessment, or both. Where only competency is in dispute, a court need only make that assessment.<sup>205</sup> However, where either the young person's diagnosis of gender dysphoria, or the proposed treatment, or both, is disputed by a parent, a best interests assessment is required.<sup>206</sup> That is also the case even where a competency assessment is complete.<sup>207</sup> Such an approach severely undermines a *Gillick* competent young person's ability to exercise autonomy, rendering an assessment of legal competence in clinical practice practically meaningless in most Australian jurisdictions.

In England and Wales, while the Divisional Court in *Bell* suggested routine court involvement is desirable where clinicians contemplate relying on their assessment that a young person is *Gillick* competent to consent to puberty blockers, it stopped short of requiring it. *Bell* would not have barred a clinician in England and Wales from providing treatment to a young person they have assessed as *Gillick* competent. Despite this, the NHS service specification for GIDS was amended in terms that suggest the court *did* require it. *Bell*, and the NHS response to it, had a chilling effect on the ability of trans youth to commence or continue puberty blockers.<sup>208</sup> While the NHS responded to the *Bell* appeal judgement in terms that increased access again,<sup>209</sup> the vestiges of the pause on access are likely still being felt.

In *AB v CD*, Lieven J held that puberty blockers do not fall into a 'special category' of medical treatment for which parental consent is insufficient; such special cases either *required* a court application or should come before a court as 'good practice'. Justice Lieven concluded parents could give lawful consent to puberty blockers to treat gender dysphoria,<sup>210</sup> but noted that 'if the clinicians consider the case to be finely balanced, or there is disagreement between the clinicians, then the case should be brought to Court'.<sup>211</sup> This statement is uncontroversial and is consistent with the courts' existing jurisdiction. The Court of Appeal in *Bell* explicitly agreed with the analysis of Lieven J in *AB v CD*, finding there is no legal requirement for routine court oversight of decisions to provide gender-affirming healthcare to trans youth in England and Wales.<sup>212</sup> The English position is less restrictive than Australia's, in affirming that routine court oversight of competency assessments is *not* required, giving far more respect to clinical competence assessments.

205 Ibid.

206 Ibid.

207 Ibid.

208 'Mermaids Statement on the Bell v Tavistock Appeal', *Mermaids* (Web Page, 17 September 2021) <<https://mermaidsuk.org.uk/news/mermaids-statement-on-the-bell-v-tavistock-appeal/>>.

209 See 'Amendment to GIDS Specification 2021' (n 60).

210 *AB v CD* (n 13) [128].

211 Ibid.

212 *Bell Appeal* (n 53) [48].

## B Can a Trans Young Person Consent Themselves?

### 1 Youth Rendered Competent by Legislation

Trans youth aged 16 years and over are treated markedly differently than their younger counterparts in some jurisdictions. In England and Wales, those over the age of 16 are granted the ability to consent by legislation. Australia has similar legislation in only one of its eight states and territories: the State of South Australia. There, a statutory presumption of capacity operates at age 16 and the legislation has also codified *Gillick*; vitiating the effect of *Re Imogen* in that State on a young person's ability to provide consent independent of parental support. Accordingly, trans youth aged 16 years and older are in a relatively similar position in South Australia and England and Wales. However, for those seeking treatment in other Australian states, the common law dictates the degree of legal authority a trans young person may have in providing their own consent to treatment.

### 2 Gillick-Competent Youth

In both Australia, and England and Wales, the *Gillick* judgement remains the authoritative statement of a young person's ability to consent to medical treatment. In England and Wales, the Court of Appeal in *Bell* affirmed the continuing significance of this judgement. In Australia, however, recent case law has arguably departed from the ratio of *Gillick* where trans youth are concerned.

In Australia, Watts J in *Re Imogen* held that a trans young person can only consent to treatment without court oversight if their parents also provide consent. That is, parents must always be asked, and any reluctance or refusal engages a requirement for court approval. Significant criticism of this requirement in *Re Imogen* has been made, given its inconsistency with *Gillick*.<sup>213</sup> In Australia, this places trans youth with unsupportive parents in a disproportionately worse situation than their peers who need not approach a court. This is particularly concerning as a lack of familial support is significantly correlated with suicidality.<sup>214</sup> This is even more concerning because trans youth experience extremely high rates of suicidality and self-harming.<sup>215</sup> This legal requirement represents a barrier to treatment in Australia that is not present in England and Wales.

The combined effect in Australia of *Re Kelvin* and *Re Imogen* is to render *Gillick* competence assessments for trans youth in most Australian jurisdictions nearly meaningless. If both parents must also provide consent, in all cases where youth are assessed as competent to consent on their own behalf, the agency of trans young people is erased. If an application is made to the Family Court on the basis solely

213 See, eg, Steph Jowett, *Consent for Medical Treatment of Trans Youth* (Cambridge University Press, 2022); Jowett and Kelly (n 3); Dimopoulos and Taylor-Sands (n 3).

214 Jaime M Grant et al, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (Report, 2011) 7; Robb Travers et al, *Impacts of Strong Parental Support for Trans Youth* (Report, 2 October 2012) 2.

215 Grant et al (n 214); Travers et al (n 214).

of a dispute as to *Gillick* competence, then a competence assessment is, in Watts J's view, all that the judge must conduct.<sup>216</sup> However, according to *Re Imogen*, all an unsupportive parent need do is challenge the diagnosis, the approach to treatment, or both, to trigger a judicial best interests assessment, again erasing the youth's agency that has been recognised by a finding of *Gillick* competence. Notably, one motivation for introducing *Gillick* competence was an acceptance of the desirability of avoiding frequent court applications; *Gillick* competence was always meant to be an assessment conducted in a clinical setting.<sup>217</sup>

In England and Wales, both *PD v SD* and the Court of Appeal in *Bell* confirmed that a *Gillick*-competent young person can consent to puberty blockers. The Court of Appeal firmly acknowledged that *Gillick* requires clinicians to assess capacity rather than judges.<sup>218</sup> However, the current Service Specification for GIDS provides that while young people under 16 may be competent to consent to puberty blockers, consent from one or both parents is sought before referrals are made to endocrinologists.<sup>219</sup> Trans youth under 16 in England and Wales may be in a similar situation to those in Australia, through clinical regulation rather than the law.

While the courts have grappled with legal questions regarding decisions about puberty blockers, no court in England and Wales has addressed the issue of *Gillick* competence for gender-affirming hormones. This was not raised, nor would it be likely to, given the type of legal proceeding and the practice of the Tavistock clinic. The application was for judicial review of the Tavistock's decisions under its protocol providing gender-affirming hormones are only given to those aged 16 years old and over. These youth are afforded the legislative presumption of competence, and hence face fewer barriers to providing their own lawful consent to treatment in England and Wales.

### (a) *Who Assesses Gillick Competence?*

In Australia, the question of who assesses *Gillick* competence is context dependent. Ordinarily, as in England and Wales, assessment of a minor's competence is undertaken by the medical professional with charge of the child's medical care in the normal course of obtaining consent for treatment. However, between 2013 and 2017, Family Court judges were the only assessors of *Gillick* competence with legal weight in decisions about gender-affirming treatment, following guidance from the Full Court in *Re Jamie*.<sup>220</sup> This situation proved problematic and

216 *Re Imogen* (n 143) 356 [59].

217 See Jowett and Kelly (n 3) 48, discussing *Gillick* (n 17) 166. The requirement of consent from both parents also removes any possibility of confidentiality for a *Gillick*-competent trans minor. That is, if consent by both parents is always required, both parents must necessarily be informed of the trans young person's diagnosis and proposed treatment.

218 *Bell Appeal* (n 53) [76].

219 'Amendment to GIDS Specification 2021' (n 60) 1.

220 See *Re Jamie* (n 103) 398 [140] (Bryant CJ), 406 [186]–[188] (Finn J), 407 [196] (Strickland J). While this is no longer true for many adolescents since the *Re Kelvin* (n 132) judgement for stage

harmful.<sup>221</sup> *Re Kelvin* removed the judiciary from routine *Gillick* competency decisions for most trans youth, but potentially left open a significant role for the judiciary where there is not full parental support, in line with comments in *Re Jamie*.

In *Re Imogen*, Watts J reserved a role for Family Court judges where a young trans person seeks treatment — potentially already assessed as *Gillick* competent by their doctor — but one or both of their parents do not consent, or dispute competence, the treatment, or the diagnosis. The judge would make a competency assessment where only competency is disputed by the parents, and this may be determinative where it is the only issue. However, his Honour’s view was that a best interests assessment will be determinative where there is dispute over the diagnosis and treatment proposed — even when the youth is judicially deemed *Gillick* competent.<sup>222</sup> Until there is further jurisprudential development, judicial assessments of *Gillick* competence are likely to continue as a legal requirement for a subset of trans youth in Australia. This approach is unjustifiably paternalistic and, given that it applies in no other contexts for young people in Australia, discriminatory.

In England and Wales, the Divisional Court’s decision in *Bell* was imbued with similar paternalism and preferred retaining a role for the court, despite not finding a legal requirement for one. This was clarified in the Court of Appeal decision, where they affirmed that clinicians rather than courts should assess *Gillick* competency.<sup>223</sup> However, the Court of Appeal did not rule out cases involving a young person’s gender-affirming treatment decision coming to court, especially ‘where there are disputes between one or more of clinicians, patients and parents’.<sup>224</sup> The practical implications of this are unclear but given the Court’s insistence that doctors assess competence rather than judges, it is difficult to envisage numerous judicial assessments of competence transpiring.

Australian law places significantly more barriers to treatment in terms of who assesses competence than England and Wales, despite both jurisdictions adopting the principle of *Gillick* competence. Given that *Gillick* was confirmed in 1992 by *Marion’s Case* to be the law in Australia, requirements for routine judicial assessments of competence emanating from *Re Jamie*, that have been revived for a subset of trans youth by *Re Imogen*, are poorly founded.

two treatment, conflicting authority exists on whether it might be required for stage three treatment: *Re Mathew* (n 137). Cf *Re LG* (n 137). It is now the case that, for most mature minors in that situation, *Gillick* competency assessments can be made by medical practitioners without the imprimatur of the Court.

221 Fiona Kelly, “‘The Court Process Is Slow but Biology Is Fast’: Assessing the Impact of the Family Court Approval Process on Transgender Children and Their Families” (2016) 30(2) *Australian Journal of Family Law* 112, 121 (‘Impact of Family Court Approval Process on Transgender Children and Their Families’).

222 *Re Imogen* (n 143) 351 [35]. See also Jowett and Kelly (n 3) 44.

223 *Bell Appeal* (n 53) [76].

224 *Ibid* [89].

### (b) What Does the Gillick Test Require of Trans Youth?

In the 2004 Australian case of *Re Alex*, Nicholson CJ noted that '[t]he circumstances in which a child or young person has the right to make his or her own decisions as to medical treatment are far from precise'.<sup>225</sup> The factors courts should consider relevant to *Gillick* competence assessments have, historically, not been clearly articulated. Where *Gillick* competence has been assessed, the factors judges have considered relevant have included the child's chronological age, maturity, emotional state, and medical evidence of their competency and understanding of their condition and the relevant treatment.<sup>226</sup> The factors courts have highlighted in respect of capacity in the context of trans youth have largely derived from the expert opinion of the child's treating doctors.<sup>227</sup>

In England and Wales, the Divisional Court in *Bell* approved the approach towards the test for capacity set out in *Re S (Child as Parent: Adoption: Consent)* ('*Re S*').<sup>228</sup> In *Re S*, Cobb J considered whether a girl aged under 16 who had given birth could give consent to place the child for adoption. Justice Cobb identified a need for 'consistency of approach to the assessment of capacity of adult decision-makers and children decision-makers'.<sup>229</sup> His Honour listed the factors that needed to be shown to establish capacity.<sup>230</sup> Justice Cobb also proffered that in order to meet the *Gillick* bar, the young person needs understanding of 'salient' matters as compared with 'peripheral' matters — while also having a 'full understanding of the essential implications of the [decision]'.<sup>231</sup> Like Cobb J, the Divisional Court in *Bell* set out a list of what needed to be understood to be able to consent to puberty blockers.<sup>232</sup> However, this approach was rejected by the Court of Appeal, which held the list covered areas of disputed fact, and 'implied factual findings that the Divisional Court was not equipped to make'.<sup>233</sup> The Court of Appeal chose not to address concordance of the *Gillick* test with the legislative test for those aged over 16 and adults.<sup>234</sup>

225 *Re Alex* (n 105) 529 [155].

226 See Mathews and Smith (n 74) 188–9.

227 See above Part IV(A)(1).

228 [2017] EWHC 2729 (Fam) ('*Re S*'), quoted with approval in *Bell Divisional Court* (n 12) [116]–[118].

229 *Re S* (n 228) [60].

230 The factors were: (a) '[u]nderstand the nature and implications of the decision and the process of implementing that decision'; (b) '[u]nderstand the implications of not pursuing the decision'; (c) '[r]etain the information long enough for the decision-making process to take place'; (d) 'weigh up the information and arrive at a decision'; and (e) 'communicate that decision': *ibid* [62].

231 *Ibid* [61].

232 *Bell Divisional Court* (n 12) [138].

233 *Bell Appeal* (n 53) [65].

234 *Ibid* [83]. The Court of Appeal did not find it useful to engage in 'a comparison between the exercise of assessing *Gillick* competence and the process envisaged under the *Mental Capacity*

The Court of Appeal decision in *Bell* places trans youth in the English and Welsh jurisdiction in a similar position to their counterparts in Australia. *Gillick* applies, rather than different context-specific guidance for trans youth. This flexibility replicates the situation for other medical treatments a mature adolescent may seek.

*(c) What Degree of Understanding Must a Trans Young Person Demonstrate?*

Another significant aspect of the *Gillick* test for competence is the extent to which a young person needs to understand information about treatment. In Australia, Nicholson CJ commented in *Re Alex*, that,

[i]t is one thing for a child or young person to have a *general understanding* of what is proposed and its effect but it is quite another to conclude that he/she has sufficient maturity to *fully understand* the grave nature and effects of the proposed treatment.<sup>235</sup>

Insofar as it requires a minor to ‘fully’ understand the treatment, the test for *Gillick* competence appears to require a higher level of comprehension than the capacity test for adults.<sup>236</sup>

In England and Wales, however, the Divisional Court in *Bell* recognised that ‘it is important not to set the bar [of capacity] too high’.<sup>237</sup> The Court approved the test for capacity proposed by Chadwick LJ in *Masterman-Lister v Brutton & Co [Nos 1 and 2]*:<sup>238</sup> a person should be able to ‘understand an explanation of that information in broad terms and simple language’.<sup>239</sup> The Divisional Court in *Bell* stated that ‘[t]he child or young person needs to be able to demonstrate sufficient understanding of the salient facts’.<sup>240</sup> Helpfully, the Court rejected an argument that, following *Montgomery v Lanarkshire Health Board*, it was necessary for a child to understand *all* the material facts to have competence.<sup>241</sup> This clarified that while a clinician may have a duty to inform the patient of all material facts and risks, the patient does not need an exhaustive understanding to possess *Gillick* competence.

*Act 2005*’, particularly because the Divisional Court’s declaration concerned under 16s to which the *Mental Capacity Act* (n 80) did not apply. Note that the analogy with the *Mental Capacity Act* (n 80) test also did not appeal to Sir James Munby in *Re X (A Child) [No 2]* [2021] EWHC 65 (Fam).

235 *Re Alex* (n 105) 118 [168] (emphasis added).

236 Adults are only required to have a ‘broad understanding’: see Mathews and Smith (n 74) 188.

237 *Bell Divisional Court* (n 12) [130].

238 [2003] 1 WLR 1511.

239 *Bell Divisional Court* (n 12) [131], quoting *ibid* [36].

240 *Bell Divisional Court* (n 12) [131].

241 *Ibid* [130], citing *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

Prior to *Bell*, there had been an interesting difference of opinion between academics on the question of whether to have capacity to consent to a treatment a child needs only to understand the proposed treatment (the Gilmore/Herring view);<sup>242</sup> or whether the child needs to understand the proposed treatment, as well as alternative treatment and the consequences of receiving no treatment (the Cave/Wallbank view).<sup>243</sup> In *Bell*, the Divisional Court's approach was consistent with the Gilmore/Herring view.

Regarding a requirement to understand alternative treatment, from a clinical standpoint, there are no genuine alternative treatments to puberty blockers and gender-affirming hormones. For those assigned female at birth, the contraceptive pill may alleviate some distress through cessation of menstruation. Without puberty blockers, however, natal pubertal development will continue. Without gender-affirming hormones, a trans young person will be unable to develop secondary sex characteristics congruent with their experienced gender. This leaves psychotherapy as the sole alternative treatment option, which, as Watts J accepted in *Re Imogen*, is 'risky and unproven' and not accepted by the majority of the medical profession.<sup>244</sup> Indeed, a treatment approach involving only psychotherapy — in contrast to the widely-accepted model of gender-affirming care — seems hard to justify given that there is no empirical evidence to suggest it would lead to improved outcomes; indeed, quite the opposite.

There is a further argument why an unreasonably high threshold for capacity is unsustainable, particularly in relation to trans youth. In this context, the issues are not simply cognitive. Whether the adolescent has capacity to consent is less a matter of intellectual ability and more a matter of identity, consistency of values, and authenticity.<sup>245</sup> Trans youth will be the experts in their own bodies and their identity. They will have 'played' with gender; and explored their bodies and identities, perhaps more than many adults.<sup>246</sup> So our understanding of capacity in this context should be less concerned with rationality and more concerned with lived experience.

#### *(d) Understanding of Only Treatment Itself or Potential Future Treatments Also?*

Similar to the potential requirement to understand 'alternative' treatments, in both the Australian and the English and Welsh jurisprudence, an issue has arisen about

242 Stephen Gilmore and Jonathan Herring, "'No' Is the Hardest Word: Consent and Children's Autonomy" (2011) 23(1) *Child and Family Law Quarterly* 3.

243 Emma Cave and Julie Wallbank, 'Minors' Capacity to Refuse Treatment: A Reply to Gilmore and Herring' (2012) 20(3) *Medical Law Review* 423, 423–49.

244 *Re Imogen* (n 143) 378 [224], [226].

245 Timothy F Murphy, 'Adolescents and Body Modification for Gender Identity Expression' (2019) 27(4) *Medical Law Review* 623, 630.

246 Simona Giordano, 'Gender Atypical Organisation in Children and Adolescents: Ethico-Legal Issues and a Proposal for New Guidelines' (2007) 15(3–4) *International Journal of Children's Rights* 365, 365–8.

whether a trans young person has needed to be assessed as competent solely for the purpose of the treatment proposed, or subsequent related treatments that may or may not be sought.<sup>247</sup> The Divisional Court in *Bell* determined that to have capacity to consent to puberty blockers, a child also had to understand the implications of using gender-affirming hormones.<sup>248</sup> This seems unsound, since normally an individual does not need to understand potential subsequent treatment in order to consent to initial treatment; one can consent to a biopsy without understanding the implications of chemotherapy. The Court had two reasons for linking puberty blockers and gender-affirming hormones as a single package. First, the court made a finding of fact that statistically nearly all children who took puberty blockers subsequently received hormones.<sup>249</sup> Second, the court considered that the taking of puberty blockers influenced the child towards receiving the hormones.<sup>250</sup>

This reasoning is highly questionable for two reasons. First, the statistical argument is irrelevant. If a person is able to understand an appropriate treatment A and consent to it, they can receive it even if they do not currently understand treatment B. This counterargument is even stronger when one considers that it is foreseeable that by the time the person requires the subsequent treatment, they will have attained the capacity to consent to it. Second, even if puberty blockers were considered to ‘confirm the chosen gender identity’ and support the decision to receive hormones, that hardly seems problematic unless such influence is clearly undesirable. Consider a patient with anorexia nervosa who consents to counselling and therapy; they may be more likely to agree to subsequent treatments, but this is no reason to deny them capacity to consent to treatment.

This issue was raised before the Court of Appeal in *Bell*. The endocrinologists at the respective hospitals adopted a different consent process and different competence assessment for the prescription of puberty blockers and provision of gender-affirming hormones.<sup>251</sup> If the law treated these as the same assessment, it would be absurd. The Tavistock and intervening hospital trusts argued that

the Divisional Court failed to appreciate the difference between a causal connection and an association, whatever the proportion of those who move from one treatment to another. The correlation may be the result of effective selection of those for puberty blockers and information sharing at the consent stage.<sup>252</sup>

The Court of Appeal chose not to offer an opinion, but noted that, ‘these judicial review proceedings did not provide a forum for the resolution of contested issues of fact, causation, and clinical judgement ... we have concluded that the

247 See Smith (n 16) 29–33.

248 *Bell Divisional Court* (n 12) [138].

249 *Ibid* [137].

250 *Ibid*.

251 *Bell Appeal* (n 53) [25].

252 *Ibid* [64].



declaration implied factual findings that the Divisional Court was not equipped to make'.<sup>253</sup>

While the Australian cases have not considered whether there is a requirement to understand subsequent treatment in order to be *Gillick* competent, they have historically treated puberty blockers and gender-affirming hormones as a 'single treatment plan', albeit consented to at different stages.<sup>254</sup> The argument to do so was advanced by counsel for the young person's parents in *Re Alex*, to avoid a subsequent court application. However, the unintended effect of this was that the legal barriers the Court deemed necessary for gender-affirming hormone treatment extended to puberty blockers, despite acknowledging puberty blockers lacked significant irreversible effects. This approach continued until 2013, when the judiciary evaluated the medical treatments separately and considered that legal requirements should be different.<sup>255</sup> Despite this, Australian courts have not gone so far as to expect knowledge and understanding of gender-affirming hormones in order for a young person to be assessed as competent to consent to puberty blockers. This approach aligns with clinical guidelines.<sup>256</sup>

The approach of the Divisional Court in *Bell* towards *Gillick* competence assessments is inconsistent with the approach elsewhere in England and Wales, and Australia. When assessing capacity to consent to initial treatment, there is no sound basis to require a young person to understand later, related, treatments they may choose not to pursue.

## C Parental Consent

### 1 Can a Parent Consent to Treatment for Their Child?

In Australia, where a young trans person just entering puberty is seeking puberty blockers and provides meaningful assent, clinicians ordinarily accept the consent of parents — now required to be *both* parents in the absence of a court order by

253 Ibid [64]–[65].

254 *Re Alex* (n 105) 122–3 [188].

255 *Re Lucy* (n 125) 561 [100].

256 The guidelines provide that treatment is individualised and does not follow a linear trajectory for all trans and gender diverse individuals — despite the adoption of the language of stages by the Australian judiciary: see Telfer et al, *Australian Guidelines* (n 1) 6. This is especially so for those who may identify as non-binary: see generally Beth A Clark et al, 'Non-Binary Youth: Access to Gender-Affirming Primary Health Care' (2018) 19(2) *International Journal of Transgenderism* 158, 159; Jennifer Hastings, 'Approach to Genderqueer, Gender Non-Conforming, and Gender Nonbinary People' in Madeline B Deutsch (ed), *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* (University of California San Francisco, 2<sup>nd</sup> ed, 2016) 69. For reporting on these youth in Australia, see Janine Cohen, 'Why This 11-Year-Old is Getting Injections to Block Puberty', *ABC News* (online, 2 March 2020) <<https://www.abc.net.au/news/2020-03-02/not-a-boy-not-a-girl-four-corners-olivia-delaying-puberty/11998826>>.

virtue of the *Re Imogen* judgement.<sup>257</sup> Where treatment involves gender-affirming hormones or surgical intervention — namely, chest reconstructive surgery for transmasculine youth — the approach has been to seek consent from *Gillick*-competent youth themselves, rather than parental consent where possible, but has not always historically required parental consent in addition.<sup>258</sup> Now, post *Re Imogen*, it does.<sup>259</sup> The current Australian position provides a clear path for treatment for those with support of *both* parents. However, court involvement for those with one or more unsupportive parents is now assured before any treatment can take place. This situation is undesirable for clinical resource allocation and the psychosocial health of trans youth. Further, from a legal standpoint, the rationale for such erosion of *Gillick* is unclear and unsupported.

In England and Wales, the Divisional Court in *Bell* did not consider the scope of parental consent, leaving it unclear whether there was scope for parental consent of the kind occurring in routine clinical practice for trans youth in Australia. Normally, if a child lacks *Gillick* competence, a parent can consent on their behalf. The prescribing Trusts acknowledged before the Divisional Court in *Bell* that where puberty blockers are used to treat precocious puberty (rather than gender dysphoria) in children as young as 7 years old, ‘parents must give that consent because of the young age of the child concerned and the nature of the treatment’.<sup>260</sup> However, the Trusts indicated that in the context of gender dysphoria, they would not proceed with treatment for a child without *Gillick* competence and would not accept parental consent. As such, the Divisional Court did not consider issues of parental consent for puberty blockers because the Trusts would not provide treatment without the child’s consent.<sup>261</sup> Subsequently, *AB v CD* addressed this issue, with the Trusts indicating they would accept parental consent alongside the child’s assent. Justice Lieven decided that consent to puberty blockers can lawfully be given by a person with parental responsibility, and does not fall within a special category requiring court oversight.<sup>262</sup> This was explicitly approved by the Court of Appeal in *Bell*.<sup>263</sup>

## 2 Can Parental Power to Consent to Treatment Exist Concurrently with Their Child?

A related question is whether a parent can consent to treatment in circumstances where their child is *Gillick* competent. In *AB v CD*, Lieven J considered this question of concurrent powers of consent, holding that parents can provide consent

257 On clinicians accepting parental consent in contexts where a young person is not *Gillick* competent, see Telfer et al, *Australian Guidelines* (n 1) 8, 23. Note difference in approach by a hospital in Western Australia: *Re G5* (n 64) [83]; *Re G8* (n 64) [35].

258 Telfer et al, *Australian Guidelines* (n 1) 24.

259 *Re Imogen* (n 143) 357 [63].

260 *Bell Divisional Court* (n 12) [127].

261 *Ibid* [47].

262 *AB v CD* (n 13) [128].

263 *Bell Appeal* (n 53) [48].

for their child's treatment provided they are not overriding the child's wishes.<sup>264</sup> This was approved by the Court of Appeal in *Bell*,<sup>265</sup> confirming the child's wishes are determinative of whose consent is lawful.

In Australia, courts have implicitly accepted that concurrent consent powers exist because the *Re Imogen* judgement *requires* parents to consent to treatment, regardless of whether there is a clinical finding of the young person's *Gillick* competence.<sup>266</sup> The reasoning for this position was not articulated. *Re Imogen* effectively accepts that parents and *Gillick*-competent youth hold concurrent refusal powers and that parental power may be exercised to veto treatment unless otherwise ordered by a court. Accordingly, young people in Australia without the benefit of full parental support face a greater barrier to treatment than their counterparts in England and Wales. This severely undermines the operation of *Gillick* in practice, and unjustifiably infringes the autonomy of the competent young person.<sup>267</sup> Australian courts should adopt the supportable interpretation of *Lieven J in AB v CD*, so that parental power only functions as a support mechanism where a young person is competent, rather than being used to override the competent young person's wishes. That approach to concurrent consent powers aligns with the essence of *Gillick* and the rights of mature young people to bodily autonomy.

### **3 What Is the Impact of Parental Disapproval, If Any, to the Path to Treatment?**

In Australia, per *Re Imogen*, parental disapproval of treatment, diagnosis, or competence imports a requirement for court approval or assessment of *Gillick* competence.<sup>268</sup> This is a significant barrier to treatment for those trans youth who are unfortunate to lack parental support, in states other than South Australia and Queensland.<sup>269</sup> It is also likely to affect a significant percentage of trans youth, as trans young people commonly experience rejecting parental behaviours in connection with gender identity; ranging from non-affirming to blocking access to gender-affirming medical care.<sup>270</sup> Crucially, in Australia, a parent does not need to

264 *AB v CD* (n 13) [114].

265 *Bell Appeal* (n 53) [48].

266 *Re Imogen* (n 143) 357 [63].

267 See Jowett and Kelly (n 3).

268 *Re Imogen* (n 143) 356 [59].

269 See earlier discussion of legislative principles in South Australia. In Queensland, these requirements are unlikely to affect clinical practice where clinicians rely on the decision in *Re A* (n 147).

270 In New York and California, youth under the age of 18 need their parents' permission to begin hormone therapy or to access gender affirming surgeries. In a study of trans adolescents in those states, among the participants who were interested in obtaining these procedures, over half reported that their parents refused to grant them permission: Kelly C Johnson et al, 'Trans Adolescents' Perceptions and Experiences of Their Parents' Supportive and Rejecting Behaviors' (2020) 67(2) *Journal of Counseling Psychology* 156, 162. See also Roberto L Abreu et al,

bring a dispute about diagnosis, treatment or competency to the court, they may merely refuse or be unavailable to provide consent. The young person,<sup>271</sup> or possibly a supportive parent, must bring the dispute to the court.<sup>272</sup> As noted above, justification for this novel interpretation of ‘dispute’ in the *Re Jamie* decision was not articulated by Watts J in *Re Imogen*.<sup>273</sup>

In England and Wales, the Divisional Court’s judgement in *Bell* indicated that parental dispute may invoke a role for the court. In respect of those aged 16 years old and over, the Court held that ‘so long as the young person has mental capacity and the clinicians consider the treatment is in his/her best interests, then absent a possible dispute with the parents, the court generally has no role’.<sup>274</sup> The Divisional Court did not clarify whether the jurisdiction would be engaged by a dispute about competence or proposed treatment. Further, it is unclear whether a court application by a disputing parent would be required to undermine the ability of a competent young person or a supportive parent to give lawful consent. Regardless, the Court of Appeal in *Bell* observed there is a possible role for courts in cases of parental dispute, which is at odds with the finding in *AB v CD* that parental power cannot be used to override the competent young person’s wishes, unless the dispute itself is around competence.

What would an English court likely decide in a dispute about competence? Herring et al suggest relevant principles can be drawn from case law on termination of pregnancy of minors.<sup>275</sup> That is, where a child lacks capacity, a court may nevertheless rule in favour of terminating a pregnancy in the face of parental opposition where the risks to the mental health of the child are greater if treatment does not occur.<sup>276</sup> However, in such circumstances the child would need to be clearly accepting of the treatment and compliant, notwithstanding their lack of *Gillick* competence.<sup>277</sup> Such principles could potentially be applied to circumstances of puberty blockers for gender dysphoria where a young person, not yet considered *Gillick* competent, is clearly distressed by the advent of puberty with clear risks to their mental health, but where parents oppose treatment.

‘Parental Reactions to Transgender and Gender Diverse Children: A Literature Review’ (2019) 15(5) *Journal of GLBT Family Studies* 461.

- 271 For an application brought by a young person with unsupportive parents, see *Re G10* [2022] FCWA 29.
- 272 In one case in Western Australia, the circumstances suggested by the hospital service to possibly denote controversy or dispute were even wider: the young age of the adolescent; the lack of evidence as to one parent’s view; the smoking of cannabis; and reports of past abuse from the uninvolved parent: *Re G4* [2021] FCWA 102, [49]. In another, the dispute or controversy centred around mere referral to a gender service, rather than treatment itself: *Re G5* (n 64).
- 273 See Jowett and Kelly (n 3).
- 274 *Bell Divisional Court* (n 12) [146].
- 275 Herring et al (n 11) 15.
- 276 *Re P (A Minor)* (1981) 80 LGR 301, cited in *Gillick* (n 17) 126–7.
- 277 *Re X (A Child)* [2014] EWHC 1871 (Fam) [12].

The Australian law regarding parental dispute, and its practical operation, significantly impedes treatment for trans youth. While the English law here is less well defined, the law on concurrent consent powers expressed in *AB v CD* suggests parental dispute would not invalidate a competent young person's consent unless a dispute about competence is brought before a court.

## VI CONCLUSION

Our analysis has shown differences between Australia and England and Wales in how the law may impede a young trans person's ability to access treatment that are superficially subtle but, in effect, of significant practical impact. Australia's body of case law erecting barriers to treatment has developed considerably since 2004, whereas English jurisprudence is comparatively more recent.

Regarding a trans young person's power to consent to their own treatment, legislation on the age of medical decision-making affords young people aged 16 years and over in England and Wales potentially greater autonomy to make their medical decisions than young people in Australia, except for the State of South Australia. The common law doctrine of *Gillick* competence operates alongside legislation in both jurisdictions, however its operation is different in Australia for decisions about gender-affirming treatment.

Regarding who assesses *Gillick* competence, Australia has a long, harmful history of requiring routine court assessment. While recently lifted for most young people, requirements for court oversight following *Re Imogen* mean judicial assessments of competence and best interests are likely to be required for many young people who do not have full parental support, before they can access treatment. In England and Wales, this is unlikely to be the case as, while the Divisional Court in *Bell* favoured routine judicial competency assessments, the Court of Appeal clarified that it is 'for doctors and not judges' to determine *Gillick* competence.<sup>278</sup>

Regarding the degree of understanding a *Gillick* competent trans young person need demonstrate, the Court of Appeal decision in *Bell* places trans youth in England and Wales in a similar position to their Australian counterparts.<sup>279</sup> In both jurisdictions, a trans young person needs to meet the ordinary *Gillick* standard, there being no context-specific guidance from the court on what they need to understand. This flexibility replicates the situation for other medical treatments that a mature adolescent may seek.

Regarding the scope of parental consent, gender-affirming treatment for young people is no longer considered 'special', in Australia or in England and Wales. Accordingly, parents may provide consent to treatment for puberty blockers and

278 *Bell Appeal* (n 53) [76].

279 The finding by the Divisional Court in *Bell Divisional Court* (n 12) that a young person would need to understand both the impacts of puberty blockers and of gender-affirming hormones was not upheld on appeal: see *Bell Appeal* (n 53) [64]–[65].

gender-affirming hormones. Of course, the *Re Imogen* requirement for dual parental consent makes clear that some special legal treatment is still being applied. While the English courts have clarified that parental consent powers exist concurrently with those of competent youth, provided they do not exercise that power to override a young person's wishes, the law in Australia has effectively taken the reverse position. Lack of parental involvement or support has a disproportionate impact on the legal ability for trans youth to access treatment in Australia, compared to their counterparts in England and Wales.

The remaining legal barriers in Australia apply *only* to trans youth lacking full parental support. By contrast, in England and Wales, the Court of Appeal in *Bell* determined there are no barriers specific to trans youth seeking care and emphasised the ongoing relevance of *Gillick*. The remaining barriers to treatment in Australia are significant as they may preclude a young person accessing timely gender-affirming medical treatment. Delay in access to treatment and lack of access to treatment both sacrifice improved psychosocial wellbeing, and are each associated with detrimental and irreversible pubertal development and psychosocial distress.<sup>280</sup> Research on the lived experience of trans youth and their families in Australia demonstrates that requirements for court oversight of medical decision-making in this context are harmful.<sup>281</sup> Moreover, they make little sense when juxtaposed against the literature on the developmental approach to capacity.

Courts should be reticent to impose specific legal barriers to gender-affirming medical treatment for trans youth. This applies especially in the case of puberty blockers, because for young trans youth, whether puberty is blocked or proceeds, there is no neutral course of action. To suggest otherwise is to misunderstand the fact that treatment is a therapeutic response to a medical issue; the absence of treatment is not a default state of knowable, static, psychological, or physical wellbeing. Gender-affirming medical treatment should be treated, legally, the same way as other therapeutic medical treatments for young people. Court involvement should be confined to situations of genuine disputes, such as where there are legitimate reasons to doubt a young person's competence. Leading research on cognitive development supports the ability of many young people below the legal age of majority to make medical decisions, particularly those who have attained 16 years of age. Parental power should not be permitted to overrule a competent young person's considered decision to medically affirm their gender.

Judges should not impose poorly founded restrictions delaying therapeutic treatment because, as Dimopolous and Taylor-Sands note, 'this is an area where the legal system causes *nomogenesis*, that is, sickness generated by law'.<sup>282</sup> Remaining ambiguities in the Australian law, notably the difference in opinions of

280 See de Vries et al, 'Outcome after Puberty Suppression and Gender Reassignment' (n 8); Costa et al (n 26); Turban et al, 'Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation' (n 10); Turban et al, 'Access to Gender-Affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults' (n 10).

281 Kelly, 'Impact of Family Court Approval Process on Transgender Children and Their Families' (n 221).

282 Dimopoulos and Taylor-Sands (n 3) 60.

Watts J in *Re Imogen* and Boddice J in *Re A*, mean future development of the case law is likely imminent. The law should facilitate gender-affirming medical care taking place under the normal legal constraints on decision-making by young people. Our analysis adds further weight to the growing consensus spanning the judiciary, doctors, legal scholars, and interest groups, that the law in Australia should be reformed to reduce unnecessary and harmful barriers to treatment for *all* trans youth. Such a progression would both better secure individual agency and autonomy, reduce unnecessary pain and suffering, and align the law with lived experience, medical science, and developmental approaches to decision-making capacity.