An Investigation of Parental Consent Principles and Their Effects on TGDNB Minors' Access to Hormone Therapy in Australia

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Abstract: In Australia, the legal and ethical discourse regarding parental consent for gender-affirming hormone therapy (GAHT) has significant complexity and represents an evolving dynamic of discourse. The role of parental consent in minors' access to GAHT has become increasingly complicated with laws and policies changing in response to societal perspectives on gender identity, the involvement and role of the courts is a determining factor in minors' access to GAHT. Simultaneously it is intensely associated with the minor's individual consent and the scope of medical practitioners' responsibilities. As established by Gillick V. West Norfolk and Wisbech Area Healthy Authority, the Gillick competency principle recognises that minors are allowed to make decisions independently if they have sufficient maturity and capacity to understand the implications and consequences of such decisions. The Australian jurisprudence, at present, was initially considered to recognise the Gillick competency principle. However, as the jurisprudence continues to evolve, the legal attitude regarding minors' access to GAHT treatment in Australia has deviated from the Gillick competency principle due to the tendency of parental protectionism in Australia. This thesis starts with the content and the reasoning of the Gillick Competency Principle, to discuss its practice and applications in Australia, as well as its implications regarding the Parental Consent Principle and the accessibility of GAHT to minors. Meanwhile, providing suggestions regarding the improvement of the present situation.

Keywords: TGDNB Minors, Transgender Healthcare, Gender-Affirming Hormone Therapy, Parental Consent, Gillick Competence Principle.

1. Introduction

With the emergence of gender awareness, an increasing number of studies have shown more minors are on gender-related therapy each year. The access to hormone therapy regarding transgender, gender diverse and non-binary (TGDNB) minors is significant. The statistics indicate that, in TGDNB's minor community, 74 % of those minors were diagnosed with depression, 72.2 % with anxiety, 25.1 % with post-traumatic stress disorder, and 79.7 % of the individuals experienced self-harm, with 48.1 % attempting to commit suicide [1]. The use of hormone therapy is a critical component of gender-affirming care and has a far-reaching impact on the physical and psychological well-being of transgender and gender-diverse minors [2,3]. With the increasing trend of transgender, gender diverse and non-binary (TGDNB) minors accessing healthcare services in Australia, greater concern has been paid to their state of access to hormone therapy, particularly regarding considerations around parental consent for gender-affirming treatment for minors. However, the restrictive framework of parental consent places certain barriers to accessing such fundamental care and results in negative outcomes [4, 5]; therefore, requiring further scrutiny and discussion. In Australia, variations in legal texts across states impact on the accessibility of hormone therapy for minors in varying extents. Based on current research, policies in several states permit minors to provide self-consent under specific conditions, while some regions require explicit parental consent or court authorization [6] - demonstrating an unequal situation, with regional variations in access to hormone therapy and support for minors. This paper will focus on parental consent laws in Australia, initiating a literature review to understand the impact of parental consent laws on hormone therapy for TGDNB minors, and to explore the underlying challenges that impact on their long-term health and wellbeing.

2. Gillick Competency Principle

2.1. Procedures for Establishing Gillick Competency Principle

The Gillick Competency Principle originates from the UK, in the case of Gillick V. West Norfolk and Wisbech Area Healthy Authority in the House of Lords. In the initial case, the judicial review proceedings challenged the legality of medical practitioners providing contraceptive advice and treatment to minors under the age of 16 without parental consent or parental knowledge. In the process, the Lords focused on responding to three major issues, including whether minors under 16 years of age have the capacity to legally consent to contraceptive treatment and instructions; whether the provision of contraceptive advice and treatment to minors under the age of 16 years without explicit parental consent violates a variety of parental rights in relation to their children; as well as whether a doctor providing contraceptive-related treatment and instruction could incur criminal liability; furthermore, it emphasised the significance of preserving the duty of confidentiality - in order for minors to access healthcare and advice without parental involvement and consent [5]. The judgement in the case demonstrated support for minors under the age of 16 to legally receive medical treatment and advice, allowing minors to consent to treatment if they are 'considered competent', while establishing the concept of the Gillick Competency Principle. The concept is frequently referred to in Lord Scarman's rationale that minors are permitted to make decisions regarding their own medical treatment when they have sufficient understanding and intelligence to enable themselves to fully comprehend what is being proposed [5].

Such a landmark judgement recognised the legitimate authority of minors to make decisions when they are determined to be sufficiently mature and capable of understanding the implications and consequences of the associated decisions [5]. In subsequent cases, the application of the Gillick Competency Principle has evolved into further areas of reproductive decision-making and treatment beyond the field of contraception, including gender-affirming hormone therapy, sterilisation, and so on. At the same time, more elaborated principles to protect the privacy of minors have been developed as well, as declared in the 2006 judgement in the case of Re Axon, Gillick competent minors have the right to confidentiality and to be protected by human rights standards when obtaining contraceptive and abortion advice [5, 7].

2.2. The Major Context of the Gillick Competency Principle

With regard to the interpretation of the Gillick principle, Lord Fraser and Lord Scarman, which are the judges of the House of Lords, offered differing views regarding the criteria and requirements for its relevant determination in Re Marion. Both Lord Fraser and Lord Scarman rejected absolute parental control regarding minor children and recognised the ability of mature minors to make decisions to make decisions for their own treatment [5]. Lord Fraser argued that minors are capable of consenting when they can understand what is being proposed and express their wishes; Lord Scarman added further to this regarding the requirement of ‘understanding’ by requiring discretion on the part of the minor in order for them to make choices that are in their best interests. In other words, Lord Scarman's reasoning requires minors to be capable of further thinking and decision-making in order to guarantee the long-term well-being and future development of minors.

In addition, another key issue is how parental decision-making should be discussed when minors have the capacity to decide - whether to remove or diminish the parents' power to make decisions and obtain information about their children's health care. Firstly, the House of Lords reached a consensus rejecting the notion that parental consent powers are the basis for controlling children as these powers exist for the benefit of the minor. Lord Scarman argued that parental consent should be excluded when the minor has the capacity to consent. He argued that the power of parental consent only exists to protect the person and property of the minor and should be ceded to the minor's children when the minor has the capacity to consent [5]. However, Lord Fraser made a dissenting view that parental consent should be sought when a minor under the age of 16 is being treated [8]. He argued that parents will make the best judgement that is in line with the well-being of the child. In cases where parents are not involved, Lord Fraser enumerated the factors that may allow for the lack of parental consent to implement treatment, including when the minor has the capacity to understand, is in a situation where he or she is unable to communicate with the parents, is in urgent physical and mental condition, and when it is in their best interests to be satisfied [5]. Their reasoning was critical regarding the associated subsequent UK jurisprudence as well as the practice.

3. Review on Parent Consent Principle in Australia

3.1. Parent Consent Principle and GAHT

In Australia, the legal principles associated with a minor's consent to gender-affirming hormone therapy have been constructed through case law relating to specialised medical treatment and are inextricably linked to the boundaries of parental consent. Cases associated with minors receiving gender-affirming treatment rely on the 1992 Australian High Court decision in the case of Minister for Health and Community Services v Marion, which considered whether a parent could legally consent to the sterilisation of a child with a severe disability. Re Marion's case established the extent to which parental consent in medical decisions can be scope of application. The jurisprudence suggests that because the medical procedures involved in the case were not therapeutic and were of a serious and irreversible nature, the court needed to be involved in parental treatment decisions as a safeguard procedure to serve the best interests of the minor whose parents could not legally consent, and whose subsequent surgical decisions were made by the court. Based on the Re Marion case related to non-therapeutic interventions and medical activities, the reasoning, in that case, has a strong and leading correlation to subsequent cases related to minors obtaining GAHT, where the court is formally involved in the consent process for obtaining treatment.

The Re Alex case in 2004 was the first case in Australia to consider hormone therapy for gender anxiety as an exceptional medical procedure, requiring court approval for both the first phase of treatment (puberty blockers) and the second phase (gender-affirming hormones) [5]. The decision was linked to several key determinants, firstly both phases of the treatment had serious irreversible consequences and therefore required family court decision-making. Secondly, one of the judges, in this case, considered that it was necessary for the court to make decisions, since Alex, the minor in this case, was not ‘capable of understanding the treatment’. However, paradoxically, that judgemental opinion, founded on Gillick competence. However, paradoxically, that judgemental opinion, is founded on Gillick competence. Finally, regarding consideration of the best interests of the minor -

hormone therapy should be distinguished from the contraceptive decision in Gillick's case, as GAHT will continue until the minor reaches adulthood.

The Re Jamie case in 2013 adopted a different approach to Re Alex in that it removed the requirement for court consent and approval for Phase I treatment [4]. The Full Court of the Family Court decided that parents could legally consent to Phase I treatment, that Phase II treatment would continue to require court consent based on the fact that Phase II treatment was irreversible, and noted that when a minor is assessed by a medical practitioner as having Gillick competency, a petition must be filed with the court regarding a determination of competency by the court. In the Re Kelvin case in 2017, the court agreed that the second stage of treatment also did not require court consent, only parental consent [4]. Re Kelvin's case went a long way to reversing Re Jamie's position that the 2 stages of treatment for GAHT were no longer outside the scope of parental authority. A court determination is not required when the parents, the minor, and the doctor consider the minor to have GAHT; treatment can be practised if all agree; if the minor does not have the competency for GAHT whereas the doctor agrees to the treatment, the parents can consent to the treatment [5].

The subsequent judgement of Re Imogen, 2020, challenged the clarity of Re Kelvin's decision. The case of Re Imogen rendered two decisions, firstly, it negated the statement in the adjudicatory guidelines that parental consent for a minor with Gillick competence was ideal, but not necessary.

Secondly, the court posited that a petition to the court needs to be filed for approval in the instance of parental disagreements. An application to the court must be filed if any type of ‘dispute’ exists between the parents, regardless of the fact that an affirmative assessment has been made regarding the minor’s Gilick competency. In other words, the Re Imogen judgement establishes the requirement of parental consent at every stage of treatment, requiring the intervention and approval of the court in the instance of parental disagreement, regardless of whether or not the minor is considered to have Gillick competence.

3.2. Parent Consent Principle and Gillick Competency Principle

Firstly, it should be noted that the Gillick principle was recognised in Re Marion's case as part of the Australian common law, as well as being the theoretical basis for Australia's approach to parental consent for a minor to obtain GAHT. Re Marion's case confirms the position adopted in Gillick's case that parental authority ceases when the minor is deemed capable of making decisions. However, Australia again appears to be somewhat conservative and overly paternalistic when it comes to the issue of GAHT. Firstly, in Re Marion, the courts were made the judge of whether a minor could be treated for GAHT and it was held that the courts could make decisions in the best interests of the minor. Re Jamie and Re Kelvin have had a degree of corrective action, in particular Re Kelvin, which held that parental consent is desirable but not necessary when a child is G-competent. In effect a return to the meaning of the Gillick principle itself, which recognises that a child can make decisions independently when he or she has G-capacity, rather than needing a particular subject to make decisions instead. But, as stated above, the judgment in Imogen negates all of this by substituting parental consent for the Gillick principle, a far cry from the meaning of the Gillick principle itself.

4. Problems Regarding the Parent Consent Procedure for Minors Accessing GAHT in Australia

The current complicated issues and contradictions remaining between minors accessing GAHT and the Parental Consent Principle in Australia include, from a legal perspective, the deviation of Australia's Gillick Competency Principle in practice from its original jurisprudence; as well as the intractable and practical social and ethical issues which integrate multi-dimensional perspectives. In general, the confluence of an unfavourable legal environment, evolving societal perspectives and inadequate familial support structures creates a context in which minors encounter significant challenges in accessing GAHT. Such an unfavourable situation has the potential to exert a detrimental impact on minors in a multitude of dimensions over an extended period of time.

4.1. The Deviation from Jurisprudence

Currently, parental consent laws and court involvement in the process of accessing GAHT for minors in Australia create dilemmas and implications from various perspectives. The complex process of GAHT for minors, which requires parental consent and court approval with conflicting views, creates significant barriers to accessing support. Based on the misinterpretation of the Gillick competency principle, Australian jurisprudence and the results of the reasoning demonstrate a deviation from the original intention of the Gillick principle. The determination of a minor's Gillick competence becomes meaningless due to mandatory parental consent requirements and court supervision. It preserves the state's ability regarding decision-making and supervision in GAHT and diminishes the power of minors for self-determination. At the same time, tensions in reasoning exist between the principle and the judgment of Re Imogen. This principle recognises that when minors can be considered to have Gillick competence, they can make decisions by themselves. However, in the judgement, the court considered parental consent to be a necessary procedure, at the same time, when a parent denies or disputes, the minor's consent becomes invalidated [5]. In the process, the minor's right to consent and to make decisions is deprived.

4.2. Court Participation in the Process Results in Further Burdens for Minors

At the same time, the court's involvement in the consent process is rather bureaucratic, and the pathologising of individual identities and genders in the courtroom further increases the harm and emotional burden on the minor. The ‘best interests’ standard applied by the court in adjudicating disputes may be contrary to the actual best interests of the minor, since the court is unlikely to be more knowledgeable than the minor themselves. Instead, when the court incorrectly determines that it is in the minor's ‘best interest’ not to receive treatment, the minor is forced to re-engage with the parent with the negative relationship in order to obtain parental consent. Despite the purpose of court supervision is to maximise the protection of TGDNB minors, current research demonstrates that the family court process causes harm to minors and their families [1]. Meanwhile, the harm caused by the court process well exceeds the risks posed by permitting minors and their parents to consent to treatment [9]. The maintenance of the status quo will exacerbate the difficulties faced by minors, as Smith asserts, it will deprive Gillick's capable minors of the ability and power to make decisions about further issues related to their individual identity [5].

4.3. The Intractable Social Issues

The persistent social issues include three major perspectives: those pertaining to parents, healthcare providers, and patients. Initially, when addressing concerns associated with parents, it is essential to acknowledge that parental consent and support are essential for TGDNB minors, including aspects such as mental health and physical health. The Australian Standards of Care for Gender Anxiety recognise the positive impact of family involvement and parental support on the transition and treatment process for minors [5, 10]. However parental support may not consistently lead to positive, utilisable outcomes, meanwhile, parental consent for minors to access GAHT raises additional ethical and legal discussions of an intersectional dimension. Parents may have difficulty accepting their child's identity, which can result in the formation of exclusionary and unsupportive attitudes. Consequently, this can lead to delays in accessing support for the minor and hinder decisions regarding the necessary medical consent [11, 12]. Based on the Re Imogen judgment, minors without identity support are exposed to further difficulties. Since the law requires parental consent as part of the necessary process to access GAHT, minors in unfavourable relationships with their parents (e.g. estrangement and rejection, domestic violence, shaming, etc.) are forced to re-engage with their parents and disclose information regarding individual privacy, at the same time creating legal impediments and financial pressures when consent is not ascertainable [4]. As a result, the requirement of parental consent can create barriers to accessing gender-based health care while having a traumatic impact on the mental health of the minor. In addition, such communication can result in further deterioration of the minor's relationship with the parents. To some extent, operating without parental support presents a more positive outcome for both the patient and the family [13]. For example, increased autonomy and decision-making power are given to the client to access treatment in a prompt and targeted manner; at the same time, the burden of decision-making is reduced for the parent [4]. In other words, mandatory parental consent processes and laws result in a diminution of the autonomy and decision-making power of individual minors. Indeed, even if a minor is adjudicated as having Gillick competence, explicit parental consent is still required to access GAHT. At the same time, parents are given the additional burdens of making decisions, to be responsible for their decisions, with the intention of achieving the greater and optimal welfare of the minors. Furthermore, it is necessary to demonstrate that the additional parental consent process presents a significant obstacle to the delivery of medical care, while simultaneously placing a considerable burden on family finances in terms of the aforementioned costs and medical expenses, as well as the immeasurable time costs associated with navigating the consent process.

For healthcare professionals, parental consent procedures and legislation restricting minors' access to GAHT frequently reveal conflicts with federal nondiscrimination principles, leading to clinical confusion and uncertainty [14]. Legal complexities further magnify the risks to the physical and mental health of minors by rendering the provision of care complicated, placing healthcare professionals in a dilemma, and potentially preventing them from prescribing - based on worries over legal and ethical components. Meanwhile, healthcare providers are challenged to balance parental authority and the interests of the minor patients when family conflicts arise, such as the need to contact the parents when the latter have not provided details of the parents, to appear in court as witnesses for defences, and so on [4]. It certainly leads to an increase in complex, additional processes in the healthcare procedure, directing more ethical questions to the physician while delaying treatment and increasing the uncertainty of treatment [15]. The aforementioned situations emphasise the significance of supportive environments in healthcare framework settings, as well as the more sophisticated legal frameworks that prioritise informed consent and patient autonomy in decision-making progress – to achieve more enhanced medical and healthcare outcomes.

For the individual minors concerned, the procedure of parental consent and the involvement of the family courts resulted in a deeper degree of suffering, particularly in the psychological aspect. The court process further imposes egregious psychological burdens on minors, including anxiety, depression, stress, and so on. Given that an individual's identity status is perceived as pathological within the context of the courts, such portrayals inevitably engender further self-doubt and anxiety in minors, as well as foster apprehension regarding the disclosure of personal and medical information [9]. Integrated with the effects of undesirable parent-child relationships mentioned above, such negative psychological attributes can be magnified considerably, which intensify the unfavourable conditions of minors, while hindering their access to treatment and support, in addition to directing them towards more negative clinical outcomes. Furthermore, the requirements regarding the parent consent procedure demonstrate that the relevant legal frameworks insufficiently consider the life experiences and vulnerabilities of transgender, gender variant, and non-binary sex minors and place them in even more marginalised and disadvantaged circumstances. Financial pressures, time delays, and immeasurable psychological stresses result in delayed access to GAHT for minors, leading to higher medical risks and negative impacts on their physical and mental health as well as their long-term development [16].

5. Suggestions

Through the review of parental consent procedures for minors accessing GAHT in Australia, this study suggests if the minor has the Gillick competency, they can be considered independently qualified to consent, and do not require a substantially more complex parental consent procedure to receive treatment, in order to achieve the goal of more prompt and effective treatment outcomes. However, further detailed research is required to support this perspective for the future practices. First of all, it is paramount to have a deeper understanding of the current legal framework and practice. By examining a wider range of cases and jurisprudence to identify the underlying causes of impediments and contradictions, as well as the logic within them. For example, in the practice of the Gillick Competency Principle, the difference in the importance of satisfying the Gillick Competency and parental consent - serves as an entry point for exploring understandings and potential ‘consensus’ on the Gillick Competency Principle, individual authority, and parental authority. Incorporating jurisprudence and practice in conjunction with state and federal law, to discuss the impact of the changing legal framework and dynamically shifting social environment on the authority of TGDNB minors in accessing GAHT, whether positive or negative. It contributes to the enhancement of minors' disadvantages as well as positively impacts within the healthcare context.

Resolving the dilemmas that legal uncertainty presents to healthcare providers is critical as well, as these uncertainties can affect the ability of healthcare providers to provide nursing care [14]. Particularly when the minor patient originates from an oppositional, unsupportive, and other undesirable family circumstances. Future research needs to focus on the role of ethical frameworks as well as legal frameworks in the guidance of provider decision-making, exploring and responding to the potential issues involved. This study proposes that ethical experts and the hospital ethics committee should be considered and appropriately incorporated to provide a more professional theoretical perspective into practice, while releasing healthcare professionals from unnecessary moral dilemmas and risks.

As part of the healthcare framework, the questions regarding how to recognise a minor as having Gillick competence require additional attention. To what extent is a minor considered to have Gillick competence? Simply a basic ability to comprehend discourses? Or requiring a sufficient understanding of the content and consequences of the treatment? If so, to what extent is the level of understanding determined to be sufficient or not? At the same time, in the context of the principle of maximising the interests of the minor, how to comprehend the maximisation of interests in this situation? In order to address the above questions, more detailed and comprehensive healthcare frameworks and guidance are required, to provide further clarity on the GAHT process, in order to achieve improved therapeutic outcomes and to facilitate the long-term well-being of the patient. Further to this, it is essential to focus on the mental health of the minor as well, therefore requiring additional psychological perspectives, as well as integrating the detailed biological and psychological professional assessments, along with the background investigation of the patient, into practice.

Furthermore, research into the socio-political landscape surrounding hormone therapy and transgender care can demonstrate the influence of public perceptions on legislative measures, which affects access to GAHT. Investigating the intersection between healthcare access, legal barriers, and the rights of transgender minors can provide valuable insights into advocacy strategies aimed at reforming controversial laws regarding gender-affirming care [17]. Meanwhile, examining the role of healthcare professionals, especially mental health practitioners, in mitigating the risks associated with non-affirming environments could further inform practice standards and guidelines [18].

6. Conclusion

In conclusion, from the review of Australia's parental consent laws and the legal framework for minors to access GAHT, this paper presents a discussion of the dilemmas and challenging factors that minors face in accessing gender-based medical support. The unfavourable legal environment creates direct barriers for minors, such as complex processes, in addition to many non-direct impediments. These non-direct impediments are associated with a variety of factors such as parents, courts, and medical professionals, and involve a great deal of ethical considerations along with legal requirements. The evolving application of Gillick competencies, the cascading legal environment, cultural and familial resistance, as well as legal and ethical confusion on the part of healthcare providers, all contribute to the healthcare access issues faced by TGDNB minors in Australia. A more balanced and detail-specified legal framework is in continuing need regarding the balance between the individual autonomy of the minor with parental authority and consent. Therefore, it is imperative to interpriate and reframe the legal framework of parental consent law in minor access to GAHT and to develop a more detailed approach to the research and more prudent practice of the Gillick Consent Principle. Incorporating the patient's individual experience and psychological state within the context and discussing the balance between autonomy, parental rights, and the best interests of the minor in the context of a sophisticated societal perspective can contribute to the improvement of the legal framework related to GAHT for minors, with the goal of improving the physical and mental health and long-term well-being of minors, as well as promoting gender equality.

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