Relationships Australia

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Chief Minister, Treasury & Economic Development Directorate
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Protecting the Rights of Intersex People in Medical Settings – Regulatory options paper

Relationships Australia National Office welcomes the work of the ACT Government to protect the human rights of people with innate variations in sex characteristics; thank you for seeking comment on the regulatory options paper released in June 2021.

The work of Relationships Australia

Relationships Australia is a federation of community-based, not-for-profit organisations with no religious affiliations. Our services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, cultural background or economic circumstances. Relationships Australia provides a range of relationships services to Australians, including counselling, dispute resolution, children's services, services for victims and perpetrators of family violence, and relationship and professional education. We aim to support all people in Australia to live with healthy and respectful relationships. Relationships Australia has provided family relationships services for more than 70 years. We are committed to:

- Collaboration. We work collectively with local and peak body organisations to deliver a spectrum of prevention, early and tertiary intervention programs with elders, men, women, young people and children. We recognise that often a complex suite of supports (for example, drug and alcohol services, family support programs, mental health services, gambling services, and public housing) is needed by people affected by family violence and other complexities in relationships.
- Enriching family relationships, including providing support to parents, and encouraging good and respectful communication.
- Ensuring that social and financial disadvantage is not a barrier to accessing services.
- Contributing its practice evidence and skills to research projects, to the development of public policy and to the provision of effective supports to families.
- Working in rural and remote areas, recognising that there are fewer resources available to people in these areas, and that they live with pressures, complexities and uncertainties not experienced by those living in cities and regional centres.

This submission is informed by:

- common law jurisprudence in relation to decision-making about medical treatment
- jurisprudence developed by the Family Court of Australia in the exercise of jurisdiction conferred on it pursuant to section 67ZC of the *Family Law Act 1975*, and
- Australia's obligations pursuant to instruments of public international law, including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the Convention on the Elimination of All Forms of Discrimination against Women; we acknowledge the Australian Capital Territory's status as a human rights jurisdiction.

Relationships Australia has also had regard to:

- the Darlington Statement of March 2017
- the Yogyakarta Principles plus 10, as adopted in November 2017, and
- Lee et al, 'Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care', 2016.[1]

These instruments provide, in our view, important elucidations of how the already existing legal rights of people with variations in sex characteristics should translate into practice.

Discussion question 1 – regulated procedures approach - options

Our comments on the options to underpin the proposed regulated procedures approach are set out below.

Creation of an offence

Relationships Australia supports the creation of an offence.

Prohibiting medical interventions that modify sexual characteristics would simply give explicit legislative recognition, in a specific context, to what has long been orthodox Australian jurisprudence about the need for 'informed consent' to clinical interventions.[2] Such a prohibition must be subject to narrowly drawn exceptions derived from well-established and uncontroversial common law exceptions relating to emergency and personal consent.

There has, to date, been judicial tolerance of interventions undertaken to modify 'atypical' sex characteristics in the absence of emergency, personal consent, judicial authorisation or other form of oversight based on rigorous inquiry, independent of the treating clinicians.[3] This has been, we suggest, a jurisprudential anomaly and represents a radical overreach of the principles articulated by the High Court in *Re Marion*.[4] It has, perhaps, arisen and persisted due to the following factors:

- evaluation of atypical bodies from narrow, medicalised perspectives, leading clinicians to recommend medicalised responses rather than working with parents and multi-disciplinary experts to support the right to bodily integrity and dignity interest through more diverse and less intrusive responses
- widespread ignorance or misunderstanding of the subjectivity underpinning clinicians' evaluations of atypical sex characteristics as being indicative of 'disorders', 'diseases' or pathologised 'differences' of sex development

[1] Lee P, A, Nordenström A, Houk C, P, Ahmed S, F, Auchus R, Baratz A, Baratz Dalke K, Liao L, -M, Lin-Su K, Looijenga 3rd L, H, J, Mazur T, Meyer-Bahlburg H, F, L, Mouriquand P, Quigley C, A, Sandberg D, E, Vilain E, Witchel S: Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care. *Horm Res Paediatr* 2016;85:158-180. doi: 10.1159/000442975.
[2] As articulated by the High Court in *Secretary, Department of Health and Community Service (NT) v JWB and SMB ('Re Marion')* (1992) 175 CLR 218 and *Rogers v Whitaker* (1992) 175 CLR 479.
[3] As in, for example, *Re Carla (Medical procedure)* [2016] FamCA 7.
[4] *Re Marion* (1992) 175 CLR 218.

- persistence, regardless of changes in the terminology used, of medicalised views of the desirability and value of 'typical' sex characteristics to individuals and their communities, with stigmatisation of 'atypical' sex characteristics as an inevitable corollary[5]
- diagnostic and technical possibilities for intervention having substantially advanced in recent decades; historically, the absence of such possibilities allowed for – and perhaps demanded – a greater acceptance of more diverse bodies (particularly in relation to sex characteristics that are not visible), and
- conflation of 'intersex' with sexual orientation and gender identity.

In general, the purpose of clinical interventions is to achieve, preserve or restore, as far as possible, an individual's ability to function. How 'ability to function' is defined is deeply subjective, and the individual's own definition may vary sharply from that of their family, community or broader culture. This concept lies at the heart of social models of disability, too: that 'disability' reflects expectations, norms and accommodations prevailing in society. Interventions to modify atypical sex characteristics reflect expectations defined by society and, in particular, by medical professionals. These expectations include appearance of bodies, including genitals, and expectations about sexual orientation, gender roles and gender expression. Such expectations do not reflect universal absolutes, but are culturally and temporally specific. Therefore, in the absence of life-threatening necessity, it is critical that children be given time and space to develop their own concept of bodily integrity and the dignity interest.

A legislative framework to regulate clinical interventions should, therefore:

- acknowledge that the right to bodily integrity and the dignity interest inhere in all people
- acknowledge broader human rights shifts over recent years which:
    - increasingly acknowledge children and young people as rights bearers, including by prohibiting intervention on the basis of rationales that conflate parental fears and aspirations with the right to bodily integrity and dignity interests of children and young people, and
    - promotes and facilitates supported, rather than substitute, decision-making in relation to medical interventions
- accord statutory protection for those interests, including by sanctioning violations of those interests and by providing accessible and meaningful mechanisms for the vindication of those interests
- preserve opportunities for children and young people to become knowledgeable about their bodies and appreciative of their uniqueness and potentiality, rather than promoting an understanding of their bodies as a diagnosis, disorder or problem in need of fixing (ie reflecting a strengths-based, rather than deficit, approach)
- support change from a culture that others, stigmatises and pathologises certain body shapes to nurture an inclusive society that acknowledges, welcomes and empowers people with diverse bodies, and

[5] See also, eg, Morgan Carpenter, 'Intersex human rights, sexual orientation, gender identity, sex characteristics and the Yogyakarta principles plus 10', (2020) *Culture, Health and Sexuality* DOI: 10.1080/13691058.2020.1781262, 4; Fiona Kelly and Malcolm K Smith, 'Should court authorisation be required for surgery on intersex children? A critique of the Family Court decision in Re Carla' (2017) 31 *Australian Journal of Family Law* 118, 130; Elizabeth Reis, *Bodies in Doubt*, 2010, Chapter 3.

- support service responses to parents to empower them to advocate effectively for the protection of children's rights.

Age or capacity

Relationships Australia considers that the framework should initially focus on children. This would:

- be consistent with the common law position that adults are presumed to have capacity to consent to medical treatment[6] which would otherwise constitute an assault,[7] with remedies available in civil and criminal law[8]
- reflect that the proposed framework would displace or modify:
    - the common law principles allowing parents to make decisions (without any requirement for external advice or approval) about medical treatment for children who are not developmentally able to make such decisions,[9] and
    - both the *parens patriae* jurisdiction recognised by the High Court in *Re Marion* and the welfare jurisdiction conferred by section 67ZC of the *Family Law Act 1975* (Cth)
- simplify the range of disparate circumstances that would need to be addressed by exceptions, and
- avoid inadvertently preventing or delaying treatment to which an adult could otherwise consent.

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[6] In the context of clinical interventions, the rule applies not only to surgery (ie direct physical contact), but also to other kinds of intervention such as radiation and the administration of pharmaceuticals: See *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* [2004] FamCA 297 per Nicholson CJ at paragraph 178; *Re Sean and Russell (Special Medical Procedures)* [2010] FamCA 948, per Murphy J In *GWW and CMW* [1997] FamCA 2, Hannon J identified section 67ZC of the Family Law Act as the source of the Family Court's jurisdiction in respect of special medical procedures and held that, for the purposes of invoking the powers conferred by Part VII of the Family Law Act, 'treatment' and 'procedure' are interchangeable.

[7] *Cole v Turner* [1704] 6 Mod Rep 149, per Holt CJ; *Collins v Wilcock* [1984] 1 WLR 1172, 1177; approved in *Re Marion* (1992) 175 CLR 218, 233 (joint judgment), 265 (Brennan J), 310-11 (McHugh J); *Schloendorff v Society of New York Hospital* 105 NE 92 (1914), 92, approved in *Re Marion* (1992) 175 CLR 218, 234 (joint judgment), 310 (McHugh J). See also *X v Sydney Children's Hospital Network* [2013] NSWCA 230 per Basten JA at paragraph 12; *Canterbury v Spence* 464 F.2d 772 (1972), 780 .

[8] *Wilson v Pringle* [1987] 1 QB 237, 249 (Croom-Johnson LJ). For the common law history of civil actions of assault and battery as vindicating the interest in bodily integrity, see *Re Marion* (1992) 175 CLR 218, referring to Blackstone's *Commentaries*, 1830: 233 (joint judgment), 266 (Brennan J), 310, 312 (McHugh J). See also *Re W (a minor) (medical treatment)* [1992] 4 AllER 627, per Balcombe LJ at 641; *Slater v Baker & Stapleton* (1767) 95 ER 860. In *Re Sean and Russell (Special Medical Procedures)* [2010] FamCA 948, Murphy J observed that 'It is by no means fanciful that parents may seek to have the court give approval (or disapproval) to a decision which falls within the limits of their parental responsibility but over which they have agonised and may be ambivalent' ([2010] FamCA 948, paragraph 67) and that 'doctors can legitimately claim to need certainty when the consequences of proceeding in the absence of proper authority are potentially very severe.' (at paragraph 68).

[9] The starting point in Australian law is that children are rights-bearers and cannot be assumed to lack decision-making capacity, as per the joint judgment in *Re Marion*: 'Nor has our law ever treated the child as other than a person with capacities and rights recognised by law.' (1992) 175 CLR 218, 237; also 238-239; see also *Re Sean and Russell (Special Medical Procedures)* [2010] FamCA 948, per Murphy J; Jones, M., & Basser Marks, L. A. (2000). Valuing People through Law - Whatever Happened to Marion? *Law in Context*, 17(2), 147–180, at 174 (references omitted).

The prohibition should reflect the recognition, in public international law, common law and the family law system,[10] that children are rights-bearers *and* that they may attain capacity to make decisions about treatment for innate variations of sex characteristics before they reach 18 years of age. The recognition of children's rights reflects:

- contemporary research demonstrating the benefits to children of being engaged, in developmentally appropriate ways, in decision-making about matters affecting them,[11] and
- broader moves away from substituted decision-making to supported decision-making.[12]

The prohibition must also be framed to reflect the uncontroversial legal position that, as children mature, their decision-making capacity expands in both degree and in the range of decisions that they have legal capacity to make, while the parental decision-making role (and that of any authorising body) diminishes correspondingly.[13]

Scope

Subject to the limitation proposed above, we support a broad formulation of the prohibition – it should apply to interventions (medical or surgical) affecting *any* child's sex characteristics. We prefer this to a prohibition confined to children with an innate variation of sex characteristics because:

- a broader approach offers maximum protection of children's bodily integrity and dignity interests, pending them reaching a developmental stage at which they can give personal consent to interventions affecting their sex characteristics, should they wish to do so
- as acknowledged in the consultation paper - a narrower prohibition would offer greater scope for circumvention, and
- a narrower approach may encourage decision-makers to interpret the prohibition by reference to diagnoses, which would be problematic as a matter of principle because it

[10] See Article 12 of the Convention on the Rights of the Child; *Gillick v West Norfolk AHA* [1986] AC 112; *Re Marion* (1992) 175 CLR 218.
[11] Such as Carson, R., Dunstan, E., Dunstan, J., & Roopani, D. (2018). *Children and young people in separated families: Family law system experiences and needs*. Melbourne: Australian Institute of Family Studies.
[12] See, for example, the https://providers.dhhs.vic.gov.au/sites/default/files/2017-07/Supporting-decision-making-quick-reference-guide.pdf); https://www.publicguardian.justice.nsw.gov.au/Pages/Supported-Decision-Making.aspx ; https://www.nds.org.au/resources/people-with-disability-and-supported-decision-making-in-the-ndis-a-guide-for-nsw-providers ; http://www.opa.sa.gov.au/resources/supported_decision_making ; https://mhaustralia.org/fact-sheet-supported-decision-making-psychosocial-disability-and-ndis . See Australian Law Reform Commission, Report 124, *Equality, Capacity and Disability in Commonwealth Laws*, 2014, which advocated that supported decision-making frameworks should replace substitute decision-making frameworks; an approach also advocated in ALRC report 131, *Elder Abuse – A National Legal Response*, 2017. Consistency of substitute decision-making with the CPRD has been questioned: ALRC Report 124, pp 56ff.
[13] As recognised by the High Court *Re Marion* (1992) 175 CLR 218, incorporating the approach taken in *Gillick v West Norfolk AHA* [1986] AC 112, 170-1 (Lord Fraser of Tulleybelton), 188-189 (Lord Scarman). See *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* [2004] FamCA 297, paragraph 224, citing the Full Court of the Family Court in *R and R: Children's Wishes* [2000] FamCA 43 and *R v R (Children's Wishes)* [2002] FamCA 383; *Re Jamie* [2015] FamCA 455; cited by Carew J in *Re Jaden* [2017] FamCA 269, at paragraph 37. See also *Hewer v Bryant* [1970] 1 QB 357, 369 (Lord Denning MR) and, more recently; *LBL v RYJ and VJ* [2010] EWHC 2665.

pathologises bodies, and as a matter of practice because diagnoses change over time, and statute does not keep pace with science.

Relationships Australia considers that personal consent is particularly important in relation to interventions that affect the structure and appearance of body parts intrinsically connected with our most intimate identities, and that alter the structure or appearance of the body of a person who is not, by reason of age, in a position to consent.

Exemptions

Subject to the above, Relationships Australia supports exemptions allowing interventions:

- where the child, having the maturity to do so, gives personal consent to the intervention (this would enable treatment of children seeking gender affirming treatment for gender dysphoria); this is consistent with contemporary Australian jurisprudence[14]
- that are immediately necessary to avoid serious, imminent, inevitable and irreparable physical harm, provided that reasonably foreseeable risks and side effects of the intervention are not disproportionate to the harm that is sought to be avoided and the intervention is the least intrusive possible (analogous with the common law doctrine of emergency)[15]
- to enable necessary biological function (eg to enable urination)
- if the child is in labour, or has just given birth, and the intervention is undertaken for medical purposes connected with the labour or birth, and
- where certain processes are followed (see discussion of administration, below).

[14] In *Re Jamie*, the Full Court of the Family Court found that if a child or young person is *Gillick* competent in respect of an intervention, then no one – not courts, doctors or parents – has any decision-making role to play: *Re Jamie* [2015] FamCA 455; see also the discussion in Williams et al, 'Re Jamie (No 2): A positive development for transgender young people' (2014) 22 *Journal of Law and Medicine* 90 at 99. Australian courts have demonstrated a willingness to recognise that children have attained *Gillick* capacity in relation to various kinds of intervention, including irreversible gender affirming intervention: *Re Jamie* [2013] FamCAFC 110; *Re Jamie* [2015] FamCA 455 (Jamie, then 15 years of age, was found to be *Gillick* competent to consent to stage 2 treatment for gender dysphoria: see paragraphs 79, 82-83); *Re Kelvin* [2017] FamCAFC 258; *Re Matthew* [2018] FamCA 161 (in which a 16 year old was held to be *Gillick* competent to consent to stage 3 intervention for gender dysphoria (a double mastectomy). See also *Re Jaden* [2017] FamCA 269, in which Carew J found Jaden to be *Gillick* competent notwithstanding medical opinion to the contrary (see paragraph 50; on the medical opinion about *Gillick* competency, see paragraphs 15, 39ff). At paragraph 49, Carew J noted that Tree J had previously rejected the argument that the test for *Gillick* competence requires a child to have 'the maximum understanding which later years may give them when their brain and personality are fully developed.' (see *Re Darryl* [2016] FamCA 720 at paragraph 14). Tree J applied the test articulated in the High Court – 'capacity to make an intelligent choice, involving the ability to consider different options and their consequences': *Re Marion* (1992) 175 CLR 218, paragraph 20. See also *Re Imogen (No. 6)* [2020] FamCA 761.

[15] *Rogers v Whitaker* (1992) 175 CLR 479, 487; *Mercy Hospitals Victoria v D1 & Anor* [2018] VSC 519, paragraph 66, citing the *Medical Treatment Planning and Decisions Act 2016* (Vic). For discussion of the emergency exception in common law, see *Wilson v Pringle* [1987] 1 QB 237, 252 (Croom-Johnson LJ); *Marshall v Curry* [1933] 3 DLR 260; *Murray v McMurchy* [1949] 2 DLR 442. See also *Re A (children) (conjoined twins: surgical separation)* [2000] 4 All ER 961.

Invalid exemptions

Relationships Australia considers that the legislation should explicitly protect children from interventions that modify their sex characteristics:

- regardless of purported consent to, or authorisation of, interventions by parents or others with parental responsibility (including child protection and child welfare authorities)
- to prevent social, emotional or relationship (including parent-child relationship) difficulties that children might otherwise be considered to be vulnerable to or at risk of, by reason of their sex characteristics
- to promote or preserve family or community cohesion
- as, or as part of, a cultural, religious or other social custom
- to prevent future harm (ie harm that does not pose an imminent threat to life)
- to prevent or mitigate the risks of development of a physical illness or disorder where there are no indications of the presence of such illness or disorder at the time of undertaking the intervention
- to promote children's psychological or emotional health (ie the psycho-social rationales referred to on page 9 of the consultation paper)
- to promote or influence children's gender identity, and
- to promote or influence children's sexual orientation.

For the avoidance of doubt, none of the preceding grounds should be regarded, in or of themselves, as being undertaken to preserve life or to enable a physical function that is necessary to preserve life.

Administration

Relationships Australia joins with other stakeholders in supporting a low cost, non-adversarial system. We are most concerned that any model ultimately adopted is child-centred and multi-disciplinary. In particular, we advocate for a mechanism by which children's interests[16] can be ascertained and advocated independently, including by eliciting children's views in developmentally appropriate ways.

As noted above, it is well-established that children have rights, including the right to decide for themselves about medical interventions. This right has been reinforced by increasing recognition, over the past decades and in a variety of contexts, of children as rights-bearers. Mounting research and commentary, across a range of disciplines, supports the agency and participation of children and young people in matters affecting them, and acknowledges the increasingly articulated desire of children and young people to have a voice in decision-making that affects them. The Australian Law Reform Commission has observed that

[16] Noting that the use of the term 'best interests' to mask unduly medicalised perspectives of a children's interests has been noted by the Committee on the Rights of the Child and is addressed by State Obligations D and E of the Yogyakarta Principles plus 10: see Morgan Carpenter, 'Intersex human rights, sexual orientation, gender identity, sex characteristics and the Yogyakarta principles plus 10', (2020) *Culture, Health and Sexuality* DOI:10.1080/13691058.2020.1781262, at 10.

> …tension between protection and participation is sometimes framed as a contest between competing principles or rights…. The Committee on the Rights of the Child has suggested that there is no tension between children's welfare or best interests (art 3) and their right to participation (art 12). Instead, they are complementary….[17]

Depending on their age and maturity, and the kind of intervention under consideration, a child may be recognised by the law as being competent to consent to medical intervention, such that the intervention will not expose clinicians to liability for assault and battery.[18] Even if a child is regarded as not having capacity to make a decision, the child's views may be sought and taken into account. This is consistent with Article 12 of the Convention on the Rights of the Child.[19] In *Re W (a minor) (medical treatment)*,[20] Lord Donaldson MR held that the lack of *Gillick* competence, while reducing the weight that ought to be given to a young person's views and wishes, did not mean that those views and wishes should be disregarded. Similarly, the Full Court of the Family Court acknowledged in 1995 that

> …the Court will attach varying degrees of weight to a child's stated wishes depending upon, amongst other factors, the strength and duration of their wishes, their basis, and the maturity of the child, including the degree of appreciation by the child of the factors involved in the issue before the court and their longer term implications. Ultimately the overall welfare of the child is the determinant. That is so because the legislation says so and also because long before specific legislation the practice of the Court in its parens patriae jurisdiction established that view. The application of that principle will be influenced by the social background of the times and, as we have indicated above, it appears to us that recent social forces have indicated that more realistic weight should be attached to the wishes of the children than may have been the practical realities in years past. But there is nothing new or surprising about that circumstance; the Family Law Act is fundamentally about the application of its general provisions in the light of changing social values.[21]

The Family Law Act provides a range of ways in which children's voices can be heard in matters affecting them. The Family Court hears and relies on evidence from children, whether directly or through an intermediary such as a family report writer or independent children's lawyer (ICL),

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[17] ALRC Report 135 of its inquiry into the Family Law System, paragraph 7.18.

[18] *Rogers v Whitaker* (1992) 175 CLR 479; see *Re Jamie* [2013] FamCAFC 110; *Re Sarah* [2014] FamCA 208 per Macmillan J at paragraph 14. Justice Strickland, speaking extra-curially, made the following observation: 'It should be remembered however that the House of Lords in *Gillick* was concerned with assessing capacity of a child aged under 16, as children aged 16 years and over can give their own consent to medical intervention – see *Family Law Reform Act 1969* (UK), s 8.' (*To treat or not to treat: legal responses to transgender young people*, Conference of the Association of Family and Conciliation Courts, 2014.)

[19] See Bryant CJ in *Re Jamie* [2013] FamCAFC 110, at paragraphs 134-135; Finn J at paragraph 188 and Strickland J at paragraph 196.

[20] *Re W (a minor) (medical treatment)* [1992] 4 AllER 627.

[21] *In the Matter Of: H Appellant/Husband and W Respondent/Wife Appeal* [1995] FamCA 30, paragraph 58, having noted such recognition in other jurisdictions, including the United Kingdom, citing (for example) Butler-Sloss LJ in *Re P (A Minor) (Education)* (1992) 1 FLR 316 at 321. In *Re Marion* (1992) 175 CLR 281, the majority accepted that the *parens patriae* jurisdiction (in all respects but for the power to make a child a ward of the state, as noted in *Fountain & Anor v Alexander & Anor* [1982] HCA 16 per Gibbs CJ and Mason J) had been vested in the Family Court by amendments in 1983 (see p 257).

appointed under the Act.[22] Relationships Australia uses both child-focused and child-inclusive practice in its Family Dispute Resolution services. *Child-focussed practice* is used where the child is too young to meet with the child consultant (generally this applies to children under 6 years of age). The child consultant meets with the parents to obtain information about the child and provides the parents with information about the likely developmental needs of the child. *Child-inclusive practice* is where a child who is deemed to be developmentally able (generally, over six years of age) meets with a child consultant. The consultant explores what the family situation looks like through the child's eyes, their experiences of the separation, and how this affects the child. Children are not asked any questions about things that parents need to decide. In both processes, the child consultant attends a joint FDR session to support the parents to understand and respond to their child's needs and experiences.[23]

Relationships Australia would be happy to discuss further the potential role for child-inclusive and child-focused practice in the proposed regulatory framework.

Discussion question 2 – tiered model for regulating deferrable medical interventions on intersex people

Relationships Australia supports a model based on:

- paramountcy of children's interests, viewed through an holistic (rather than medicalised or clinical lens)
- recognition that personal consent is the best way to ensure concordance of interventions with holistically-defined best interests, subject only to narrowly drawn exceptions as described above, and
- where personal consent is not possible, but it is suggested that intervention should not be deferred until children are *Gillick* competent – accessible and expert sources of oversight and guidance in respect of proposed interventions.

In principle, we see merit in differentiating between higher and lower risk interventions, and interventions that have greater or less far-reaching and enduring consequences for children. We are, however, concerned that the approach outlined in the boxed note on p 8 may be too permissive, allowing significant scope for 'reading down' the prohibition by reference to medicalised values and goals. We are also concerned that the approach described might allow scope for interventions for reasons that have previously been regarded as acceptable, but that do not reflect contemporary understanding of children's agency and status as rights bearers.

[22] A range of constraints have impaired the efficacy of ICLs (eg the concern has often been expressed that independent children's lawyers, because of timing constraints, do not have sufficient – or indeed any – opportunity to talk directly to children themselves: see Kaspiew et al, *Independent Children's Lawyers Study*, Final Report, 2nd edition, 2014)) The importance, to children's healthy development, of being heard in matters affecting them has recently been the subject of a major research project by the Australian Institute of Family Studies: see Carson et al, *Children and young people in separated families: Family law system experiences and needs*, 2018, https://aifs.gov.au/publications/children-and-young-people-separated-families-family-law-system-experiences).

[23] McIntosh, J. E. & and Long, C. M., *Children Beyond Dispute - A Prospective Study of Outcomes from Child focused and Child Inclusive Post-Separation Family Dispute Resolution*, Final Report, Attorney-General's Department, 2006.

We would welcome clarification on how the distinctions set out in the boxed note would be applied.

Discussion question 3 – oversight and advisory bodies

Relationships Australia supports:

- multi-disciplinary oversight and guidance
- consistent and transparent processes
- high quality and accessible information and education being made available to children, their parents and treating clinicians (including risks about benefits and risks of not performing an intervention, or deferring an intervention)
- high quality and accessible counselling from expert professionals, for children and their parents
- access to peer support for children and their families
- oversight and guidance mechanisms being accessible, affordable and - most importantly - child-centred, and
- rigorous record-keeping obligations, complemented by a statutory right of access to records to be conferred on children in respect of whom interventions are conducted.

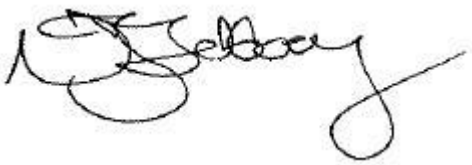
Broadly, we agree with the elements of the framework on page 9. We would, however, urge that child-centred practice be elevated in its significance to the overall framework, and support centring children's views as the primary reference point.

Conclusion

Relationships Australia welcomes the work being undertaken by the ACT Government to protect the human rights of people with innate variations in sex characteristics. These rights have not, in our view, been given sufficient visibility or accorded sufficient weight, and have been too readily de-valued relative to subjective medicalised expectations of what bodies should look like and how they should function. We further welcome the Government's willingness to consider mechanisms by which children's voices can be sought, heard and taken into account, in accordance with their public international law rights.

We would, of course, be delighted to discuss further any aspects of this submission.

Thank you and kind regards,



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