NEW SOUTH WALES

Laws and Policies for Social and Medical Transitioning

Youth and Minors

Version 1.0

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Active Watchful Waiting Inc.

www.aww.org.au

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About This Document

This document provides comprehensive information about New South Wales's laws, policies, and practices regarding youth who identify as transgender or gender diverse. It covers both social transition in schools and medical transition through healthcare services.

Who This Is For

This resource is designed for:

- Parents and families navigating these issues
- Educators and school administrators
- Healthcare providers
- Legal professionals
- Policymakers and researchers
- Anyone seeking factual information about current laws and practices in New South Wales.

Methodological Note

This document distinguishes between statutory law, government policy, and contested or emerging practices. Where policies reflect current administrative positions rather than settled law or consensus, this is explicitly noted. Terminology relating to gender, identity, and culture is reported as used in official documents, while recognising that such terms may be contested or interpreted differently within communities and academic literature.

Our Approach

This document is committed to truthful, neutral reporting. We recognise that gender identity issues in childhood and adolescence involve complex questions where reasonable people disagree. Our goal is to provide accurate information about the legal and policy landscape without advocating for any particular position.

What we do:

- Use precise, descriptive language.
- Identify contested terminology and concepts.
- Acknowledge uncertainties and evidence gaps.
- Show tensions between competing principles and interests.
- Document how policies work in actual practice, not just stated intentions.
- Include significant legal developments and shifting medical perspectives.

What we don't do:

- Use lobby language from either advocacy perspective.
- Present contested claims as established facts.
- Assume readers share any particular worldview.
- Advocate for or against any approach.
- Paper over complexities or uncertainties.

We believe parents, professionals, and policymakers are best served by accurate information that respects their intelligence and allows them to understand the full landscape —including areas of genuine uncertainty and legitimate disagreement.

Document Structure

This document is organised into five sections:

1. Social Transition in Schools: Policies regarding name, pronouns, uniforms, and facilities; parental involvement; and current practices

2. Medical Transition (Healthcare Access): Availability of puberty blockers, hormones, and surgeries; regulatory frameworks; and recent developments

3. Age Thresholds and Capacity: Legal frameworks for minors' medical consent and how they apply to gender-related decisions

4. Anti-Discrimination and Child Welfare Laws: Legal protections and child welfare considerations

5. Key Court Cases and Notable Developments: Legal precedents and significant events shaping current practice

Important Context

Evolving Landscape: Laws and policies in this area are changing rapidly. International systematic reviews (including the UK's Cass Review, and policy shifts in Sweden, Finland, and Norway) have identified significant evidence gaps regarding medical interventions for gender-dysphoric youth. Australian states are currently awaiting national NHMRC guidelines expected in 2026. This document reflects the situation as of January 2025.

Contested Terminology: Language in this field is highly contested. Terms like "gender-affirming care," "social transition," "conversion therapy," and even "transgender" carry different meanings for different stakeholders. We use precise, descriptive language and flag when terminology is contested or when we're quoting specific sources.

Evidence Quality: There is ongoing debate about the evidence base supporting various interventions. Where evidence quality is contested or acknowledged to be weak, we note this explicitly. Medical and judicial perspectives have shifted significantly in recent years as systematic reviews have identified limitations in existing research.

Practical vs. Policy: There can be significant gaps between written policies and actual practice. We attempt to document both: what official guidance says and how it tends to be applied in real-world situations.

Limitations

This document:

• Is not legal advice. Consult qualified legal counsel for specific situations.

• Is not medical advice. Consult qualified healthcare providers for medical decisions.

• Reflects the situation as of January 2025 and may not capture very recent developments.

• Cannot cover every individual case or circumstance.

• Focuses on laws and policies; does not attempt to resolve underlying philosophical, ethical, or medical debates.

How to Use This Document

You can:

- Read it cover-to-cover for comprehensive understanding.
- Jump to specific sections relevant to your situation.
- Share it with others navigating these issues.
- Use it as a reference when engaging with schools, healthcare providers, or legal systems.
- Compare it with other states' documents to understand jurisdictional differences.

References are provided throughout to allow verification of claims and further research.

Updates and Feedback

Given the rapidly evolving nature of this field, we anticipate updating these documents periodically. If you identify factual errors, significant omissions, or have suggestions for improvement, please contact Catherine Karena at contact@aww.org.au.

We are committed to factual accuracy and welcome corrections or clarifications that improve the document's reliability.

About Active Watchful Waiting Inc.

Active Watchful Waiting Inc. is a not-for-profit organisation focused on child protection policy work, particularly around evidence-based approaches to supporting gender-distressed youth. Our work emphasises:

- Comprehensive assessment and exploration before medical intervention.
- Recognition of the complexity of gender distress in young people.
- Importance of parental involvement and informed consent.
- Evidence-based practice and protection from premature interventions.
- Transparent information sharing to support informed decision-making.

While our organisation holds perspectives on these issues, this state documentation project is designed to be a resource for people of all viewpoints by providing factual, neutral information about the legal and policy landscape.

For more information about our work, visit www.aww.org.au

New South Wales – Laws and Policies for Social and Medical Transitioning (Australia, Dec 2025 Update)

Glossary

Gender Identity

Definition (as used in contemporary policy and guidance documents):
Gender identity refers to a person's internal sense of being male, female, both, neither, or something else. Under current policy frameworks, a person's gender identity does not require medical transition, legal recognition, or external validation. It is treated as a self-declared and subjective characteristic.

In practice, this means:
A person's stated **gender identity** is accepted as valid regardless of their biological sex, physical characteristics, or legal status, and is expected to be recognised in social, educational, and institutional settings. *Side-by-Side Comparison*:

Policy / Advocacy Language	Plain-English Meaning
"Gender identity refers to a person's deeply held sense of being male, female, or something else."	A person decides for themselves what gender they are, based on how they feel.
"Applies regardless of medical or legal transition."	No medical treatment, diagnosis, or legal change is required. A declaration alone is sufficient.
"Includes people who do not conform to traditional gender norms."	Anyone who does not fit typical expectations of male or female behaviour, expression, or roles may be included.
"Recognises a spectrum of gender identities."	Gender is treated as open-ended and subjective rather than fixed or biologically defined.
"Protection applies even without medical affirmation."	Institutions are expected to act on a person's stated identity, even if there is no physical or legal change.
"Respects diverse gender experiences."	Challenges or disagreement with a person's self-declared identity may be treated as discriminatory.

Plain-Language Summary for Readers

> In practical terms, current policy definitions of *gender identity* mean that a person's self-description alone determines how they are recognised in law and policy.
>
> This approach removes biological sex as a determining factor and replaces it with self-identification. Institutions are expected to treat that self-identification as authoritative, even in the absence of medical, legal, or social transition.

Why This Matters

Understanding how *gender identity* is defined in policy is important because this definition carries significant practical and legal consequences.

When gender identity is treated as a **self-declared, internal characteristic**, rather than something grounded in biological sex or observable criteria, it reshapes how institutions are expected to operate. Decisions that once relied on objective categories—such as sex—are instead guided by personal identification.

In practice, this affects:

- **Schools**, where policies may require staff to treat a child as a different sex based solely on the child's declaration, regardless of age, maturity, or parental involvement.
- **Healthcare settings**, where self-identification can influence clinical pathways, safeguarding decisions, and consent frameworks.
- **Single-sex spaces and services**, where traditional sex-based protections may be reinterpreted or overridden.
- **Legal and regulatory frameworks**, where discrimination protections may be expanded without clear boundaries or evidentiary thresholds.

Because the definition relies on subjective self-identification rather than observable or verifiable criteria, it also creates uncertainty for institutions tasked with balancing competing rights—such as privacy, safety, fairness, and freedom of belief.

For this reason, understanding how "gender identity" is defined is not a semantic issue. It directly shapes policy decisions, institutional obligations, and the lived experience of individuals affected by those policies.

Inclusion

Policy definition (as commonly used):
"Inclusion" refers to the active incorporation of individuals or groups—particularly those identified as marginalised—into social, institutional, and organisational spaces, with the aim of ensuring equal participation, recognition, and opportunity.

In contemporary policy usage, inclusion often requires institutions to **adapt their structures, language, and practices** to accommodate the identities, experiences, or needs of specific groups.

What "Inclusion" Means in Practice

In modern policy contexts, *inclusion* generally means:

- Adjusting rules, language, or environments so that no one feels excluded
- Prioritising the experiences and self-described identities of marginalised groups
- Treating non-inclusion as a potential form of harm or discrimination
- Expecting institutions to actively demonstrate inclusion, not merely avoid exclusion

Importantly, inclusion is no longer understood as *access on equal terms*, but as **active accommodation**.

What Is Often Left Unsaid

While the term sounds universally positive, the way “inclusion” is applied in policy often involves trade-offs that are not made explicit.

In practice, inclusion can mean:

- **Redefining existing categories** (such as sex, privacy, or safety) to accommodate new identities
- **Prioritising one group’s inclusion** even when it conflicts with another group’s rights, boundaries, or needs
- **Reframing disagreement as exclusion**, rather than as a legitimate difference of perspective
- **Shifting responsibility** from institutions balancing competing rights, to individuals expected to adapt

This is why the term often functions less as a neutral descriptor and more as a **normative directive** — it tells institutions *what they ought to do*, not merely what exists.

Plain-English Summary

> In current policy use, “inclusion” means actively reshaping rules, language, and environments so that people who identify in certain ways feel recognised and affirmed — even when this requires changing long-standing norms, redefining categories, or limiting other people’s expectations of privacy, safety or fairness.

Affirmation / Gender Affirmation

Policy definition:
In education and healthcare policy, *affirmation* refers to the practice of recognising and supporting a person’s self-declared gender identity. This typically involves treating the individual as the gender they identify with, regardless of biological sex, medical transition, or legal status.

Affirmation may include changes in language, pronouns, names, records, facilities access, and expectations around behaviour or presentation.

What “Affirmation” Means in Practice

In practice, gender affirmation commonly includes:

- Using a student’s chosen name and pronouns
- Treating a student as belonging to the sex or gender they identify as
- Allowing access to facilities, activities, or spaces aligned with that identity
- Framing non-affirmation as potentially harmful or discriminatory

Affirmation is often described as a **supportive or protective approach**, particularly for children and adolescents who experience gender distress.

What Is Often Not Made Explicit

While the term sounds neutral or supportive, “affirmation” in policy contexts generally means:

- **Accepting self-declared identity as true and authoritative**, rather than exploratory or provisional
- **Discouraging questioning or neutrality**, particularly by teachers or professionals
- **Treating disagreement or hesitation as potentially harmful**
- **Embedding a specific interpretation of gender identity into institutional practice**

In education settings, affirmation may occur without parental knowledge or consent, and without clinical assessment, depending on jurisdictional guidance.

Plain-English Summary

> In policy contexts, “affirmation” means accepting and acting upon a person’s declared gender identity as real and authoritative — not as a belief to explore, but as a status to be recognised and upheld.

Social Transition

Policy definition:
Social transition refers to non-medical changes made to align a person’s social role or presentation with their identified gender. In school settings, this is often framed as a reversible and low-risk form of support.

What Social Transition Includes

In practice, social transition may involve:

- Using a different name or pronouns
- Changing school records or class lists
- Wearing different uniforms
- Accessing different toilets or change rooms
- Being treated socially as a different sex

Although described as “social,” these changes often have formal, institutional, and lasting effects.

What Is Often Overlooked

While described as “non-medical” and “fully reversible,” social transition:

- Can reinforce a fixed gender identity at an early age
- May increase psychological commitment to that identity
- Can shape peer, teacher, and institutional responses in lasting ways
- Is often the first step in a broader pathway that may later include medical intervention

In educational settings, social transition frequently occurs **without clinical assessment** and sometimes without parental knowledge or consent.

Plain-English Summary

> "Social transition" means treating a child as the opposite sex (or another gender identity) in everyday school life, even though no medical or legal change has occurred. Although described as reversible, it often establishes expectations and social realities that are difficult to undo.

Discrimination

Policy definition:
In contemporary gender policy, *discrimination* refers to any action, rule, or practice that treats a person less favourably because of their gender identity or expression, or that fails to accommodate that identity within institutional settings. Discrimination may be understood as **direct** (explicitly denying access or opportunity) or **indirect** (maintaining policies or practices that are said to disadvantage a person on the basis of their gender identity).

What "Discrimination" Means in Practice

In the context of gender identity policy, discrimination can include:

- Declining to recognise or use a person's self-declared name or pronouns
- Maintaining sex-based rules or spaces that exclude individuals who identify differently
- Applying uniform standards (e.g. single-sex sports, facilities, or dress codes) without modification for gender identity
- Questioning or declining a person's asserted identity

Under this framework, *intent is often considered irrelevant*; the impact on the individual's sense of inclusion or affirmation is prioritised.

What Is Often Overlooked

While the concept of discrimination is intended to protect against unfair treatment, in gender policy contexts it can also:

- **Reframe disagreement or boundary-setting as harm**, even when applied consistently

- **Override sex-based protections** by redefining them as discriminatory
- **Create conflicts between protected characteristics**, such as sex, belief, and gender identity
- **Shift the burden of accommodation** entirely onto institutions or others, regardless of competing rights or practical constraints

As a result, actions taken to preserve privacy, safety, or fairness may be reinterpreted as discriminatory if they do not align with gender identity claims.

Plain-English Summary

> In current policy use, “discrimination” often means failing to fully recognise or accommodate a person’s self-declared gender identity, even when the rule or practice in question applies equally to everyone. This reframing can turn ordinary boundaries or safeguards into alleged acts of harm.

Misgendering

Policy definition:
Misgendering refers to the act of referring to a person using language (such as pronouns, titles, or forms of address) that does not align with that person's self-declared gender identity.

In policy contexts, misgendering is typically framed as a form of harm or discrimination, particularly when it is repeated or perceived as intentional.

What "Misgendering" Means in Practice

In institutional settings, misgendering may include:

- Using pronouns that correspond to a person's biological sex rather than their declared gender identity
- Referring to someone using terms such as "male" or "female" contrary to their self-identified gender
- Recording or speaking about a person in ways that do not reflect their stated identity
- Failing to update names or titles in records or communications

In many policy frameworks, the *effect* of the language used is prioritised over the speaker's intent.

What Is Often Overlooked

While misgendering is framed as a harm to be avoided, policy treatments often do not distinguish between:

- **Deliberate hostility** and **good-faith disagreement or error**
- **Personal belief or perception** and **institutional discrimination**
- **Involuntary or unavoidable situations**, such as sex-based language used for clarity, safety, or record-keeping

As a result, individuals may be expected to adopt language that conflicts with their understanding of sex or reality in order to avoid allegations of harm or discrimination.

Plain-English Summary

> In current policy use, "misgendering" means referring to someone in a way that does not match their self-declared gender identity. Even when unintentional, this can be treated as discriminatory, placing an obligation on others to adopt and use specific language regardless of personal belief or context.

Dead naming

Policy definition:
Dead naming refers to the act of using a person's former name — typically a birth name — after they have adopted a different name as part of a gender identity transition. In policy and institutional contexts, it is generally framed as a form of disrespect or harm.

What "Dead naming" Means in Practice

In schools, workplaces, and other institutions, dead naming may include:

- Using a person's previous legal or birth name instead of their chosen name
- Referring to a person by a name associated with their sex at birth
- Failing to update records, documents, or communications to reflect a new name
- Accidental or administrative use of a former name where systems have not been changed

In many policy frameworks, intent is considered secondary to impact; even inadvertent or unavoidable use may be described as harmful.

What Is Often Overlooked

While framed as a matter of respect, the concept of dead naming can raise practical and ethical questions:

- **Legal and administrative realities:** Legal names may still be required for records, identification, safeguarding, or accountability purposes.
- **Memory and habit:** Family members, teachers, or colleagues may use a former name unintentionally, particularly in long-standing relationships.
- **Competing rights and duties:** Institutions may be required to maintain accurate records or communicate clearly with parents, courts, or regulators.

In policy settings, the expectation to avoid dead naming can place individuals or institutions at risk of complaint even when acting in good faith or in compliance with legal obligations.

Plain-English Summary

> In policy use, "dead naming" refers to using a person's previous name rather than their chosen one, and is often treated as harmful or discriminatory. This applies even when the name is legally accurate, historically accurate, or used without intent to offend.

National Context and Recent Developments

Family Court Rulings:

The legal framework for youth gender transition in Australia has been shaped by key Family Court decisions. Earlier cases (e.g., *Re: Jamie* 2013) treated puberty blockers and hormones as "special" medical procedures requiring court approval, but *Re: Kelvin* (2017) eased that by allowing parents and doctors to consent to treatment without court if everyone agreed. In *Re: Imogen* (2020), however, the Family Court ruled that if there is **any dispute** between parents, child, or doctors about proposed gender treatment, a court order is required before proceeding.[1]

Most recently, *Re: Devin* (2025) has had nationwide impact. In that case, Justice Andrew Strum found a 12-year-old child was not truly "dysphoric" but rather exploring gender, and he **ordered that the boy be protected from puberty blockers** and any cross-sex hormones[2]. The father who opposed medical treatment was given sole parental responsibility, overriding the affirming mother.[2] Justice Strum's 58,000-word judgement delivered a scathing critique of "gender-affirming" dogmas, noting the clinic's experts provided no empirical basis for claiming a child's gender identity is fixed and innate.[3][4] He highlighted evidence that **minors cannot fully grasp the long-term consequences** (like effects on fertility and sexual function) and questioned whether a child of 10 or 11 can truly comprehend an "immutable" gender identity.[3][5]This landmark ruling signalled that courts may take a more cautious stance, emphasising that a child's best interests may require **"leaving all options open" and avoiding irreversible interventions at an early age.**[6]

In the wake of *Re: Devin*, judges have openly doubted that minors can ever validly consent to puberty blockers or hormones given the unknown risks to their future adult life.[7] Together, these cases underscore that while gender dysphoria treatment is available, it is subject to **rigorous judicial oversight** whenever there is disagreement, to ensure the young person's welfare is paramount.

NHMRC Draft Guidelines (2023–25):

Australia is currently overhauling its national clinical guidelines for treatment of gender dysphoria in minors. The National Health and Medical Research Council (NHMRC) convened an expert panel in 2023 to draft evidence-based guidelines.[8] Importantly, the NHMRC guidelines are tasked with using the international GRADE system to rigorously evaluate evidence quality.[9] This will **replace the 2018 Australian "standards of care"** (developed by the Royal Children's Hospital in Melbourne) which had been adopted nationwide despite being a low-quality guideline that **failed to rate the quality of their evidence for treatment recommendations.**[9]The new draft guidelines are expected to provide interim advice on puberty blockers by mid-2026, with a full guideline by 2028.[10] The NHMRC panel is weighing the findings of multiple systematic reviews from **Finland, Sweden, the UK, Canada as those concluded the evidence for paediatric gender transition is very weak and uncertain.**[11] The mere existence of this review has signalled that gender-affirming care for youth in Australia is **not "settled" science or policy** but rather an area under active scrutiny. It is anticipated that the NHMRC-endorsed guidelines will set a stricter, evidence-grounded standard of care, potentially influencing negligence law (courts tend to judge care by the accepted professional standards).[8]

In short, Australia appears to be moving toward a more cautious, evidence-based approach, in line with several European countries that have recently dialled back early medical interventions.

Federal and Global Developments: Federally, discrimination on the basis of "gender identity" has been unlawful since 2013 under the Sex Discrimination Act 1984 (Cth).[12]. However, debates continue over related policies (for example, religious school exemptions, removal of single sex spaces and sports categories) and there is **heightened attention on terminology and framing**.

Notably, in late 2025 the U.S. Department of Health and Human Services, under a new administration, proposed sweeping rules to restrict gender treatments for minors nationwide, referring to puberty blockers, cross-sex hormones and surgeries as **"sex-rejecting procedures".**[13] The U.S. Health Secretary announced plans to deny federal Medicaid/Medicare funding to any hospital providing such treatments to minors,[13] citing a newly commissioned HHS report that concluded paediatric transition was a "huge mistake" made on scant positive data.[14]

This sharp change in language and policy abroad illustrates the increasingly polarised global debate. Australian policymakers are mindful of international trends: for example, the federal Health Minister acknowledged overseas reviews when commissioning the NHMRC review.[15] In the United Kingdom, the Cass Review (2022) led to the NHS curtailing routine puberty blocker use and closing its youth gender clinic in favour of holistic care.[16] Sweden, Finland and others have also **"pulled the emergency brake"** on affirmative treatment for minors, now prioritising psychological support and careful case-by-case approval for hormones.[17][18] These international shifts are often cited in Australian discussions.

It should be emphasised that **gender-affirming care for minors is a matter of active debate and review in Australia and globally**, rather than a settled consensus. Several Australian states are conducting or facing inquiries (as detailed below), and professional bodies are updating guidance. In Parliament, calls for caution are growing: for example, a motion in the Western Australian Legislative Council in Dec 2025 urged the state to suspend new paediatric transitions until the new evidence-based guidelines are in place.[19] While Australia upholds the rights and dignity of transgender individuals (reinforced by anti-discrimination laws and school inclusion policies), there is a clear trend toward more *evidence-led and carefully regulated* practices in the healthcare context.

(The following section provides a New South Wales update, covering five key areas: Social Transition in Schools, Medical Transition (Healthcare Access), Age Thresholds and Capacity, Anti-Discrimination and Child Welfare Laws, and Key Court Cases or Notable Influences.)

New South Wales (NSW)

Social Transition in Schools

NSW public schools operate under Department of Education policies requiring equitable treatment of all students, including those who identify as transgender or gender diverse. Legal Issues Bulletin 55 and related guidance documents outline procedures for supporting students who express a gender identity different from their sex recorded at birth.[24][25].

In practice, students in NSW schools may request to be addressed by a name and pronouns different from those on official records, wear uniform items corresponding to their expressed gender identity, and access facilities (toilets, changing rooms) aligned with that identity. The Department's guidance indicates that principals should develop individualised support plans for such students, typically in consultation with the student and, where possible, their parents or carers.[26]

Parental Involvement and School Discretion

NSW policy creates potential tension between parental rights and student autonomy. While the stated preference is to involve parents in planning any identity-related changes at school, the guidance allows principals to proceed without parental consent if they form a "reasonable belief" that involving parents would not be in the student's "best interests"—for instance, if parents are assessed as likely to be unsupportive and this might create "risk of harm" to the student.[27] [28] [29]

These terms—"best interests" and "risk of harm"—are subject to interpretation. In practice, "risk of harm" in this context often refers to anticipated emotional distress from parental non-affirmation rather than abuse, neglect, or safety threats as those terms are traditionally understood in child protection law. This represents a significant expansion of schools' authority to act as substitute decision-makers regarding children's identity-related matters.

Privacy provisions further complicate parental involvement: information about a student's gender identity is treated as sensitive personal information under NSW privacy law, and staff are instructed not to disclose it to others—potentially including parents—if doing so "would harm the student." Schools are advised to seek legal counsel when students and parents disagree about gender-related matters.[30]

Administrative Procedures

Under current NSW policy, students are enrolled using the name and sex recorded on their birth certificate. However, principals have discretion to use a different name in day-to-day school operations for students who identify as transgender.[31] Formal changes to official enrolment records typically require legal name or sex marker changes, though practical accommodations can be made regardless.

The guidance states that deliberate use of a student's former name ("deadnaming") or birth-sex pronouns by staff or students may constitute bullying or breach conduct codes.[32] Students must be permitted to wear uniforms corresponding to their expressed gender identity, as refusing such accommodation could constitute indirect discrimination under anti-discrimination law.[33]

NSW does not mandate a standardised statewide protocol for these situations, unlike some other jurisdictions. Instead, schools develop case-by-case support plans addressing toilet access, sports participation (generally inclusive for students under 12; case-by-case assessment for older students under competitive sport exemptions), and responses to bullying.

Legislative Context

A 2020 proposed Parental Rights Bill would have prohibited teaching "gender fluidity" concepts and required schools to notify parents if children expressed gender identities at variance with their sex. The bill did not pass following a parliamentary inquiry that found it potentially inconsistent with anti-discrimination law and departmental policy. NSW schools therefore continue under existing inclusion policies rather than any parental notification mandate.

Exemptions:

Under the NSW Education Act 1990, Section 26, parents may apply to the Secretary of the Department of Education for exemption from particular courses of study on religious grounds.

Section 26 states:

"26 Certificate of exemption from attending particular classes

(*1) The parent of a child enrolled at a government school may give the Secretary written notice that the parent conscientiously objects on religious grounds to the child being taught a particular part of a course of study.*

(2) The Secretary may accept any such objection and grant a certificate exempting the child from attending classes relating to the part of the course concerned if satisfied that the objection is conscientiously held on religious grounds."

Parents may submit written objections to their child attending classes on topics such as gender identity, overly graphic sexual content, or comprehensive sexuality education.

Applications should be sent to:

Murat Dizdar PSM
Secretary of the NSW Department of Education
GPO Box 33, Sydney NSW 2001
Template exemption letters for each year level can be found at:
https://www.indefenceofchildren.org/take-action under "Gender Identity Exemption Letters"

Current Practice

In summary, NSW schools may facilitate what is termed "social transition"—changes to name, pronouns, presentation, and facility use—on a case-by-case basis. The stated ideal involves agreement between student and family, with schools implementing the student's expressed identity. However, when parents do not consent, NSW schools have latitude to proceed based on student welfare assessments, particularly with older students, while seeking legal guidance when conflicts arise. The governing legal framework combines NSW anti-discrimination law (which prohibits less favourable treatment based on transgender status) with duty of care obligations. [34] [35] All such decisions require consideration of student safety and wellbeing, with schools also managing what information is shared with peers or the school community based on privacy principles.

Medical Transition (Healthcare Access)

New South Wales hosts several major gender identity services for minors, primarily the Children's Hospital at Westmead (Sydney) and John Hunter Children's Hospital (Newcastle). These clinics have historically followed what proponents call a "gender-affirming model"—an

approach that, following psychological assessment, may lead to prescription of puberty-suppressing medications (gonadotropin-releasing hormone analogues) for adolescents in early puberty, and later cross-sex hormones (oestrogen or testosterone) for older teenagers.

Regulatory Framework

NSW lacks state-specific legislation restricting such interventions. Practice is instead guided by a combination of national clinical guidelines (primarily the 2018 Australian hormonal treatment recommendations, though these are acknowledged to have limitations), clinician judgement, and evolving family court jurisprudence. Both the 2018 guidelines and their successors are under review nationally, with new NHMRC guidelines anticipated in 2026.

In 2021, following the Family Court decision Re: Imogen, NSW Health issued internal guidance emphasising that both parental consent and comprehensive multidisciplinary assessment are expected before commencing hormonal interventions for patients under 18. [36][1] This guidance explicitly noted that where any parent or medical professional has reservations, court approval should be sought. NSW's Consent to Medical Treatment manual (Section 8.12) states that "where there is any dispute or controversy about the proposed [treatment], a court order is required" before proceeding.[36]

Even absent dispute, the guidance is to ordinarily obtain both parents' consent to confirm no disagreement, in addition to the minor's consent if they are or are not deemed competent (Section 8.12.2 paragraph G). [1][37]

Clinical Pathways

In practice, youth in NSW typically undergo psychological evaluation and counseling before any medical intervention. Puberty-suppressing medications may be considered around Tanner Stage 2 of puberty (often ages 10-13) for those diagnosed with persistent gender dysphoria. Cross-sex hormones are generally considered around age 16, sometimes slightly earlier case-by-case, following assessment protocols adapted from international practice.

Since 2020, NSW practitioners have adopted more cautious approaches. Clinicians typically require mental health assessments and often seek second opinions before initiating hormonal treatments. The **Family Court's role** is now mostly in the background unless there's disagreement: after *Re: Kelvin*, if parents and doctors agree and deem the child competent, they do not need court approval. But since *Re: Devin*, NSW hospitals are cognisant that courts might intervene to stop treatment even if one parent objects and the other consents. As a result, NSW providers ensure extensive documentation of the informed consent process (covering risks like effects on fertility, bone density, etc.). There is also an emerging practice of referring complex or contentious cases to an ethics committee or seeking legal advice pre-emptively.

Emerging Practice Changes

There are indications of slowing rates of new hormonal initiations pending clearer guidance. While NSW has not instituted a formal moratorium (unlike Queensland's 2025 pause), the clinical climate emphasises careful monitoring. Alternative approaches, including exploratory psychotherapy, are receiving renewed attention for younger patients, consistent with evolving international practice following systematic reviews in the UK (Cass Review), Sweden, Finland, and Norway that identified weak evidence bases for medical interventions.

The state government has indicated it will adapt protocols once national guidelines are released, while closely monitoring the NHMRC evidence review process.

Surgical Interventions

Gender-related surgeries are rare for minors in the NSW public system. (Specific numbers for *gender-related surgeries* on minors at Westmead and John Hunter are scarce in public data, but recent reports show large patient numbers at their gender clinics (like Newcastle's Maple Leaf with 487 patients by mid-2023) focusing on puberty blockers/hormones, with surgeries being rarer and generally for older teens (16+)). Procedures such as mastectomy or genital surgeries are not offered to patients under 18 through standard pathways. Any exceptions—for instance, a 16-17-year-old seeking chest masculinisation surgery—would require either court approval or, minimally, exceptional clinical justification with independent oversight, as such procedures may constitute "special medical treatment" outside typical parental authority. A 2019 Family Court case permitted chest surgery for a 17-year-old trans-identified male patient in NSW, illustrating that irreversible interventions may be authorised in specific circumstances deemed to be in the young person's best interests with proper consent processes.

Current Status and Outlook

In summary, NSW provides access to medical interventions for gender dysphoria in minors under an increasingly regulated framework. Public gender identity clinics continue operating with growing emphasis on comprehensive assessment and informed consent protocols. Disputes are referred to courts. Wait times for public clinic services are substantial (often many months), reflecting both high demand and careful gatekeeping procedures. Some families seek private care for faster access, though private endocrinologists in NSW generally follow similar protocols to manage medico-legal risk.

As one NSW Health Minister noted in mid-2023, any significant practice changes would be examined, but NSW would await the NHMRC systematic review before major policy shifts. The current environment is therefore one of cautious provision: families navigate a system that remains open to evidence-based interventions while applying increasingly stringent assessment and consent requirements. It should be noted that the regulatory and clinical landscape may shift substantially once the NHMRC guidelines are released in 2026, potentially affecting all aspects of practice documented here.

Age Thresholds and Capacity

New South Wales has statutory provisions regarding minors' capacity alongside general common law principles. Under the Minors (Property and Contracts) Act 1970 (NSW), a young person aged 14 or older can consent to medical or dental treatment, and that consent is legally effective.[38] Section 49 indicates that 16 and 17-year-olds are generally presumed capable of consenting to medical care without parental involvement in most circumstances.

These statutory rules operate alongside the common law Gillick competence standard, which holds that a minor of any age can consent to treatment if they have sufficient maturity and understanding of its nature and consequences. Conversely, if a minor lacks that understanding, parental consent is required for treatments within the zone of parental authority.[39]

For gender-related medical treatments, capacity assessments are particularly stringent. Puberty blockers and hormone therapy are recognised to have significant long-term implications regarding fertility, sexual development, and lifelong medical commitment. NSW Health policy explicitly acknowledges that courts have questioned whether minors can fully comprehend such treatments. Even if statutory provisions might permit 14 or 15-year-olds to consent under the Minors Act, doctors apply careful Gillick assessments: whether this particular adolescent is mature enough to understand the implications of halting puberty or initiating cross-sex hormones, including attendant risks and uncertainties.

In practice, clinicians generally consider only older adolescents (16+) likely to meet capacity thresholds for hormones, typically with parental support. If a minor is deemed not sufficiently mature, decision-making falls to parents or, if parents disagree or if treatment might exceed parental authority, to the court.[40] [41]

Some treatments may exceed the scope of parental consent: NSW's Consent to Medical Treatment manual notes that interventions constituting "special medical treatment" (irreversible, high-risk, or non-therapeutic) may require approval by the NSW Civil and Administrative Tribunal or the Court. [42] Historically, irreversible gender-related surgery on minors falls in this category, requiring court approval per Marion's Case precedent. Hormonal treatments since Re: Kelvin are regarded as within parental consent scope if the child is assessed as Gillick competent or if the court hasn't ruled otherwise.

Age 16 represents an important threshold in NSW practice. Generally, 16-year-olds are considered capable of consenting to medical care, and doctors often obtain both the teenager's consent and parental consent as a safeguard for hormone therapy. Ages 14-15 occupy a grey area: while the law recognises their consent as valid, the complexity of gender treatments prompts clinical caution about relying on sole consent from someone this age.[43][7] Under 14, NSW law provides no independent weight to the minor's consent for significant medical decisions, requiring parental consent except in emergencies.

Notably, Justice Strum in Re: Devin (2023) suggested that perhaps no minor—particularly pre-pubertal children—can truly comprehend impacts on future sexuality and fertility.[44][45] While this represents one judge's view in a specific case, it reflects growing judicial caution about minors' capacity for these decisions. NSW practitioners consequently apply case-by-case assessments with effectively higher age thresholds for irreversible interventions, with most minors receiving hormones being mid-to-late teenagers rather than younger adolescents.

Anti-Discrimination and Child Welfare Laws

Anti-Discrimination Framework

NSW's Anti-Discrimination Act 1977 includes protections for "transgender status," defined to cover individuals identifying as a gender different from their birth sex, including those who have obtained gender recognition certificates and those in the process of social or medical transition. The Act prohibits schools, employers, service providers, and others from treating individuals unfavourably or engaging in harassment based on transgender status.[25][34]

For educational contexts, NSW schools cannot lawfully expel or refuse enrolment to students based on transgender status, [34] nor can teachers deny such students access to class activities on that basis. The law permits some exemptions: single-sex schools may refuse admission to transgender students in certain circumstances, though this area involves legal complexity. Religious schools currently have federal exemptions potentially allowing them to exclude or discipline transgender-identified students on religious grounds, though this remains socially controversial. The NSW government announced plans in late 2023 to tighten state laws to provide protections for LGBTQ students even in religious schools, though these reforms were still under development.

The NSW Department of Education reinforces statutory obligations through policy, instructing schools they have a legal duty to eliminate discrimination against transgender-identified students and accommodate their needs.[46][47] This encompasses names, pronouns, uniforms, and facility access; failure to accommodate could constitute indirect discrimination (a neutral rule disadvantaging transgender-identified individuals without reasonable justification).[48][49]

Child Welfare Framework

NSW child welfare law (Children and Young Persons (Care and Protection) Act 1998) addresses abuse and neglect without specifically categorising any particular approach to a child's gender identity. However, debate exists about whether withholding gender identity-related medical interventions could constitute neglect or psychological harm.

If a child is at risk of significant harm (including psychological harm from rejection or unreasonable refusal of necessary medical care), Family and Community Services can intervene. Theoretically, if medical professionals deemed that a transgender-identified teenager urgently required treatment and a parent unreasonably refused, child protection involvement might be considered to ensure the child's medical needs are met.

To date, no documented NSW case has removed a child from parents solely for declining to affirm a gender identity or refusing medical interventions. Typically, such disputes proceed to Family Court, which can override parental refusal if it determines treatment serves the child's best interests. Conversely, NSW authorities have not treated parental support of a child's gender identity as abuse, though sceptics have in some cases alleged that early social transition of young children constitutes harm.

"Conversion Practice" Debate

The term "conversion therapy" or "conversion practices" regarding gender identity is contested. Historically, "conversion therapy" referred to coercive or abusive attempts to change sexual orientation. Its application to gender identity is more recent and less clearly defined.

NSW has not enacted legislation specifically defining or prohibiting "conversion practices" related to gender identity. After other states moved to ban such practices, the NSW Government announced intentions to introduce prohibitions, with details under consultation with stakeholders to avoid unintended consequences (such as criminalising exploratory psychotherapy or ordinary parental conversations).

Advocacy organisations have pressed for legislation that would prohibit any therapeutic approach not immediately affirming a stated gender identity. Others argue this conflates exploratory therapy or "watchful waiting" approaches with genuinely coercive or harmful practices. The definitional boundaries remain contested.

Even absent specific legislation, therapists or doctors engaging in practices deemed harmful could face professional disciplinary action or discrimination complaints. The NSW Ombudsman has investigated health service delivery for transgender-identified youth to ensure proper consent processes, framed as quality oversight rather than child protection intervention except in cases of potential harm.

Guardianship and Special Medical Treatment

NSW's Guardianship Act 1987 includes provisions for "special medical treatments" requiring tribunal consent when patients cannot consent for themselves. In 2016 regulations, "gender reassignment procedure" for individuals lacking capacity was listed as requiring such approval—applicable, for instance, if a 15-year-old with intellectual disability required gender-related surgery, triggering NSW Civil and Administrative Tribunal oversight.

Routine hormonal therapy for competent minors with parental consent does not fall under this special treatment category, per Family Court precedent (Re: Kelvin). However, irreversible surgical interventions on minors would require court approval following the Marion's Case precedent.

Summary

NSW law aims to protect transgender-identified youth from discrimination while providing child protection mechanisms for situations of genuine harm. The state is moving toward formally prohibiting coercive attempts to change gender identity, though definitional debates continue. Anti-discrimination protections are strong, and regulatory bodies like the NSW Office of the Children's Guardian have incorporated trans-inclusive guidance in out-of-home care standards.

The legal framework attempts to ensure that gender-questioning youth are protected from discrimination, bullying, and abuse while also protecting them from premature medical interventions through court oversight mechanisms and evolving standards of care. How "harm," "best interests," and "necessary care" are defined in practice remains subject to ongoing legal, medical, and social contestation.

Key Court Cases or Notable Cases Influencing Practice

Being Australia's largest state, NSW has figured prominently in legal developments regarding medical and social interventions for gender-dysphoric youth:

Re: Imogen (2020)

This case directly involved a 16-year-old NSW patient ("Imogen," assigned male at birth, identifying as female) whose parents disagreed about hormonal treatment (mother supportive, father opposed). Justice Watts in Sydney's Family Court reaffirmed that when any dispute exists—whether between parents or between medical opinions—the court must determine whether treatment serves the child's best interests. The judgement emphasised the necessity of court evaluation of a young person's capacity when contested, and stressed the importance of robust diagnosis, including consideration of other conditions that might present similarly to gender dysphoria.

Following Re: Imogen, NSW Health promptly updated internal guidance instructing clinicians to seek legal advice or court orders if not all parties (including both parents) consent to treatment. The practical effect: any indication of disagreement now triggers a requirement for court involvement rather than proceeding at the clinical level. This case reinforced that NSW practitioners cannot rely on one parent's consent alone when the other parent objects.

Re: Devin (2023) – A Watershed Case

Though decided in Victoria, this Family Court decision has profoundly influenced NSW practice. The case involved a 12-year-old child (assigned female at birth, identifying as male, known as "Devin") whose father supported commencement of puberty blockers while the mother opposed.

Justice Strum's decision to refuse authorisation for puberty blockers marked a significant departure from previous judicial approaches. The judgement contained several elements that reverberate through NSW medical practice:

1. Critique of Clinical Practices: Justice Strum explicitly criticised the gender clinic's approach, finding inadequate consideration of alternative diagnoses and questioning whether the clinic had properly explored whether the child's distress might stem from factors other than gender dysphoria.

2. Endorsement of "Watchful Waiting": The judgement praised a cautious, exploratory approach over early medical intervention, representing judicial scepticism toward the prevailing clinical model.

3. Capacity Concerns: Justice Strum suggested that minors—particularly pre-pubertal children—may be categorically unable to comprehend the lifelong implications of interventions affecting future sexuality and fertility, regardless of apparent maturity.

4. Evidence Base Questions: The decision highlighted uncertainties in the evidence supporting paediatric gender medicine, noting that treatments with unknown long-term outcomes were being offered to patients with variable capacity to consent.

This decision has prompted NSW clinicians to reassess their threshold for intervention, strengthen alternative diagnostic considerations, and apply heightened scrutiny to capacity assessments, particularly for younger patients.

Langadinos Negligence Lawsuit (2022-ongoing)

This NSW Supreme Court case represents the first known medical malpractice claim in Australia related to gender identity medical interventions. Jay Langadinos, who at age 19 was prescribed hormones and later underwent surgeries in Sydney, subsequently detransitioned and filed suit against her psychiatrist, alleging negligence in approving transition without adequately diagnosing other mental health issues.

While the case has not reached judgement, its mere filing has had substantial effects on NSW medical practice:

• Heightened Documentation: Practitioners have become acutely conscious of the need for thorough differential diagnosis (evaluating autism spectrum conditions, trauma histories, depression, and other mental health factors) and meticulous consent processes.

• Professional Anxiety: The case has created what some describe as a "cooling effect," with both public and private clinicians becoming more conservative in initiating treatments.

• Regulatory Attention: The case prompted professional bodies to revisit standards of care. The Royal Australian and New Zealand College of Psychiatrists issued 2023 guidance emphasising comprehensive mental health assessment for gender-dysphoric youth—a response likely influenced by the litigation.

The ultimate outcome could establish legal precedent regarding duty of care in gender dysphoria treatment. Even without final judgement, the case has contributed to tightening of clinical practices.

Other Notable Developments

• School Tribunal Case (2019): An NSW Civil and Administrative Tribunal decision found that refusing a transgender-identified student use of preferred facilities constituted unlawful discrimination, providing guidance that students must generally be accommodated according to their expressed gender identity in school settings unless specific exemptions apply.

• Dr. Patrick Toohey Medical Board Proceedings (2023): The psychiatrist named in the Langadinos lawsuit faced medical board complaints. While details remain confidential and no public disciplinary action was announced, the proceedings indicate that professional regulators are reviewing standards of care in gender identity medicine.

Impact on Practice

NSW's landscape has been substantially shaped by these legal developments. The combined effect of Re: Imogen, Re: Devin, and the Langadinos litigation has pushed practice toward:

• Rigorous assessment standards

• Judicial review of contested cases

• Heightened attention to informed consent and capacity evaluation

• Greater consideration of alternative diagnoses and non-medical interventions

• Extensive documentation of clinical decision-making

These cases have positioned NSW as a jurisdiction where both supportive provision and critical scrutiny coexist, ensuring that policies and practices are continuously tested against legal principles of child welfare, informed consent, and duty of care.

Conclusion

This document has outlined the current legal and policy framework for social and medical transitioning of minors in New South Wales as of January 2025. Several key themes emerge:

Evolving Standards: NSW operates in a period of transition, with clinical practices under increasing scrutiny following landmark court decisions (Re: Imogen, Re: Devin) and pending national evidence-based guidelines from the NHMRC.

Tensions Between Rights: The framework attempts to balance competing interests—student autonomy, parental authority, evidence-based medicine, anti-discrimination protections, and child welfare—often with significant discretion left to schools, clinicians, and courts to resolve on a case-by-case basis.

Uncertainty Acknowledged: Key concepts like "best interests," "risk of harm," "capacity to consent," and appropriate standards of care remain contested both legally and medically. International systematic reviews have identified significant evidence gaps, particularly regarding long-term outcomes of medical interventions.

Practical Variability: Despite policies and guidance, actual practice varies significantly depending on institutional culture, individual clinician judgement, family circumstances, and local interpretation of legal requirements.

Parents, educators, and healthcare providers navigating these issues should be aware that:

- Laws and policies continue to evolve rapidly
- Professional guidance may change as evidence reviews conclude
- Court decisions are shaping practice in real-time
- What is permitted today may be restricted tomorrow (or vice versa)

This document provides a snapshot of a dynamic situation. Readers are encouraged to verify current requirements with relevant authorities and seek qualified legal or medical advice for specific circumstances.

For updates to this document or to report corrections, contact: contact@aww.org.au

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