# 8. Minors

## 8.1. Can I treat a Minor without consent in an emergency?

Yes. Section 174 of the *Children and Young Person's (Care and Protection) Act* allows a Medical Practitioner to carry out medical treatment on a child (15 or under) or young person (aged 16 or 17) without the consent of the child or young person, or a parent of the child or young person, if the Medical Practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person to save their life or to prevent serious damage to their health.

## 8.2. Can I treat a Minor in an emergency if they or their parents previously objected and refused the treatment?

Section 174 the *Children and Young Person's (Care and Protection) Act* provides a Medical Practitioner with authority to treat a minor in an emergency without consent.

However, where the various treatment options are known well before the treatment becomes urgent, treatment options should be discussed with the Minor and/or the parent(s) before the situation becomes an emergency. This would apply in situations such as where a family has a known objection to blood products and it is known that their child will require heart surgery. Where consensus cannot be reached between the treating team and the family, it may be necessary to obtain a court order to provide guidance as to whether the treatment can proceed before the situation deteriorates into an emergency. Legal advice can be sought from the Ministry of Health's Legal Branch if necessary.

## 8.3. What is a Mature Minor and when can they consent to non-emergency treatment?

Generally, a Minor is capable of independently consenting to or refusing their medical treatment when they achieve a sufficient level of understanding and intelligence to enable them to understand **fully** what is proposed. This means that there is no set age at which a child or young person is capable of giving consent. However, there are specific and additional consent requirements for Minors undergoing gender affirming medical treatment. Please see section 8.12 below.

Health Practitioners must decide on a case-by-case basis whether a Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed.

The legal position relating to a Minor's capacity to consent was established by an English case known as *Gillick*. *Gillick was* approved by the High Court of Australia in a case known as *Marion's* case. The *Gillick* case holds that a child's capacity increases as they approach maturity or in other words, the authority of a parent decreases as their child's capacity increases.

The significance of the proposed treatment will be a relevant factor in assessing whether a Minor has capacity to consent. For example, it may be likely that a 15-year-old would be assessed as having the capacity to consent to receive contraceptive treatment, but less likely that she would be assessed as having the capacity to consent to a heart transplant. The child's capacity to consent will need to be assessed carefully in relation to each decision to be made. If a Medical Practitioner assesses a Minor as *Gillick* competent (also known as a Mature Minor) and the Minor can give valid consent, then the consent of the parent or guardian will not be required. However, where the Minor agrees, it is good practice to involve the family in the decision-making process where appropriate.

Where a practitioner assesses a Minor to be a Mature Minor, the *Consent to Medical Treatment (Adults and Mature Minors)* form should be used.

Where a Minor is not considered to be a Mature Minor, the consent of a parent or guardian is required and the *Consent to Medical Treatment (Minors)* form should be used. Depending on the age and understanding of the minor, effort should be made to include the Minor in the decision-making and consent processes.

Pursuant to the *Minors (Property and Contracts) Act 1970*, if a Minor aged 14 and above consents to their own medical treatment the Medical Practitioner may rely on that consent as a defence to a claim against the Medical Practitioner for assault or battery. Also, where medical treatment of a Minor aged less than 16 years is carried out with the consent of a parent or guardian of the Minor, the Minor cannot make a claim against the Medical Practitioner for assault or battery. Health Practitioners relying on consent from a Mature Minor aged 13 and under should be especially diligent when assessing the patient's capacity to consent, as these legal protections will not apply.

**Example**

Peter is a 14 year old who presents to emergency with a deep laceration to his arm after falling off his bike. The Health Practitioner explains that the cut requires stitches and that this will require a local anaesthetic. Further, that the consequences of not performing the stitches would be possible scarring and infection.

The Health Practitioner forms the view, in speaking with Peter, that he fully understands the proposed treatment, and the risks and consequences of not undertaking the treatment, and as such deems him to be a Mature Minor able to consent to his own treatment. When time allows and with Peter's consent, the Health Practitioner calls Peter's mother to confirm the consent.

The following is suggested as a **general guide** only and will not apply to all Minors in all circumstances. When considering the table below, Health Practitioners should be aware that when applied, the doctrine of *Gillick* competence or the Mature Minor may necessitate variations to these recommendations.

Table 1: Maturity Guide for Minor's Capacity to Consent to Medical Treatment

| Level of maturity & understanding | Recommendation for Obtaining Consent |
|---|---|
| Immature and insufficient understanding (may be 13 and under) | Consent from a parent or guardian must be obtained (Attachment B) |
| Intermediate understanding (may be 14 and 15) | Consent from the young person may be sufficient. However, the consent of a parent or guardian should also be obtained, unless the young person objects to this (refer discussion above on *Gillick* Competence) (Attachment A or B, depending on the young person's capacity) |
| Mature understanding (may be 16 and 17) | Consent of the young person will be sufficient in most cases (refer discussion above on *Gillick* Competence) (Attachment A) |

## Further guidance

- *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112
- *Secretary of the Department of Health and Community Services v JWB and SMB* [1992] HCA 15 (Marion's case)

## 8.4. Can a Minor refuse treatment?

A Minor who has capacity to consent to their own treatment may also refuse treatment.

A parent or guardian may also refuse treatment on behalf of a Minor who does not have capacity provided such refusal is in the best interests of the child.

However, a court can potentially override a decision of a Minor with capacity, or the decision of a parent or guardian, to avoid serious consequences for the Minor. In this situation, the court would consider the Minor's age and maturity, and make a decision in the Minor's best interests.

There is no State Form to document the refusal of treatment by or on behalf of a Minor. Where a Minor with capacity, or the parent/guardian of a Minor, refuses treatment, the procedure below should be followed and documented in the Health Record.

## 8.5. Non-emergency treatment in case of refusal of consent or conflict between the parent and the Minor

The following is the suggested procedure to follow where clinically indicated treatment is not emergency treatment and consent is refused by either the parents of a Minor, or Minor with capacity or there is conflict between the parent(s) and the Minor:

- Establish that there is no suitable alternative treatment available to which consent would be forthcoming.
- If there is doubt about the Minor's capacity to consent or refuse in their own right, consider obtaining a specialist opinion on capacity.
- Where there is a dispute about the appropriateness of the treatment plan, obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient.
- Attempt to reach agreement by counselling and repeat discussion with the family. These efforts should be documented.
- If applicable, explain to the parent(s) and patient that although the treatment is not urgent at this stage, if it is not provided in a timely manner, the situation may become urgent. Explain how the delay would affect the patient.
- In circumstances where the parents do not consent to treatment on behalf of their child, consider whether the refusal of treatment means that there are reasonable grounds to suspect that the Minor is 'at risk of significant harm' to the degree that a report must be made pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998*. When a report is made to the Child Protection Helpline or the Child Wellbeing Unit because the parent or guardian(s) have refused to consent to treatment, parents should generally be told before the report is made that the Health Service intends to notify the Department of Communities and Justice, unless doing so would place the child or any other person at risk. Making a suspected risk of significant harm report to the Department of Communities and Justice may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents.
- As a last resort, a court order may be sought authorising the treatment. In such cases, support may also need to be given to the family to assist them to obtain legal advice. The matter should be escalated within the Health Service and advice can be sought from the Ministry of Health Legal Branch.
- All discussions and statements and wishes about treatment should be documented in the Minor's Health Care Record.

**Example**

Sarah is a 17-year-old patient who has Hodgkin's disease and is about to start her third round of chemotherapy following a relapse of the disease. Sarah and her family are followers of the Jehovah's Witness faith and object to having a blood or platelet transfusion. Sarah and her parents have provided a written, signed document to her Medical Practitioner refusing blood or platelet transfusions. Sarah's Medical Practitioner has over 20 years' experience with patients in similar situations and has advised that Sarah will die without chemotherapy treatment. Sarah has a 70% chance of being cured of the disease with chemotherapy treatment, but this treatment will necessitate a blood transfusion, without which Sarah is likely to die from anaemia.

Sarah and her parents seek to have the chemotherapy treatment but refuse to consent to a blood or blood product transfusion. Sarah has been assessed by expert Medical Practitioners as a Mature Minor. She is fully supported by her parents in her decision.

As Sarah is a minor, her refusal of treatment may potentially be overridden by her parents or the court, notwithstanding the fact she is both intelligent and mature. However, before approaching the court, the Medical Practitioner should consider following the procedures set out in this Consent Manual and:

(a) consider any alternative appropriate treatment for which consent would be forthcoming

(b) consider obtaining a second opinion from a suitably qualified Medical Practitioner to confirm the prognosis and treatment plan

(c) attempt to reach agreement with Sarah and her family by repeat discussions and counselling

(d) if no agreement can be reached, consider whether the refusal of treatment means that there are reasonable grounds to suspect that Sarah is 'at risk of significant harm' to the degree that a suspected risk of significant harm report must be made to the Department of Communities and Justice pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998.*

Finally, the Medical Practitioner should escalate the issue within the Health Service and urgently seek advice from Ministry of Health Legal Branch to obtain an appropriate court order for guidance on a treatment plan. In this situation, the court may invoke its' *parens patriae* jurisdiction to make an order based on the best interests of Sarah. In making its decision the court is likely to take into account the nature of the disease, the nature of the treatment, the reasons for the treatment, the desirability of the treatment, the risks to Sarah's health with and without the proposed blood transfusions, the faith and views of Sarah and her parents, and the views of the attending Medical Practitioners.

## 8.6. When can a Minor consent to sexual health treatment?

As for all medical treatments, to provide sexual health treatment, a Health Practitioner must be satisfied that the Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed, taking into account the significance of the treatment. The Health Practitioner should document in the Health Record the assessment of the Minor as having sufficient understanding and intelligence to consent to sexual health treatment.

It is generally established that a Mature Minor may consent to the prescription of hormonal contraception (including the oral contraceptive pill, injectable and implantable hormones and long-term reversible contraception including intrauterine devices) and treatment for sexually transmitted infections provided the Health Practitioner assesses the patient as having capacity to give informed consent. Such assessments must be made on a case-by-case basis and are dependent on professional judgement.

In circumstances where a Health Practitioner decides that a Minor seeking sexual health treatment is not sufficiently mature to consent to the treatment, the Health Practitioner should talk to the minor indicating there is a need for parental or guardian involvement in the consent process and discuss consent options with the minor.

Health Practitioners who have reasonable grounds to suspect that a child is at risk of significant harm (for example, where it is apparent that the patient's sexual partner(s) is/are more than two years older than the patient) are required to make a report to the Department of Communities and Justice pursuant to the mandatory reporting provisions of the *Children and Young Persons (Care and Protection) Act 1998*. However, the making of such a report does not preclude the Mature Minor from consenting to the medical treatment nor does it preclude that treatment being provided.

## 8.7. Who is able to consent on behalf of a Minor if their parents have separated?

The consent of either parent to their child's medical treatment is usually enough, as the law makes it clear that each parent has full responsibility for each of their children who are under 18 and parental responsibility is not affected by changes to relationships (that is, if the parents separate or are divorced).

There are two circumstances where the consent of either parent may not be enough:

- Where no formal court orders have been made, and one parent consents to treatment and the other refuses. The recommended way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child's best interests.
- Where a court has made an order stipulating that a particular parent has particular responsibilities, that is, for health care decisions. In this case, consent must be obtained in accordance with that order.

The court can make a number of different types of parenting orders which may set out matters such as who the child will live with, how much time they will spend with the other parent or the allocation of parental responsibility.

Health Practitioners should assume that either parent can consent (alone) unless a court order stipulating something different is brought to their attention.

Health Services may develop local level policies and procedures for establishing the existence or otherwise of court orders where the parents of a Minor have separated. Legal advice from Ministry of Health Legal Branch can be sought if there is uncertainty.

## 8.8. Can a parent or guardian of a minor delegate their responsibility for providing consent to another adult?

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their Minor child to another adult. This may occur more often in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, might be responsible for giving consent on their behalf.

Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the Minor's Health Record. If the delegation was given verbally, it should be confirmed with the parent or guardian and documented in the Minor's Health Record.

If a Minor presents with an adult other than a parent, the Health Practitioner should attempt to ascertain the adult's relationship to the child and whether the adult is the child's guardian.

Where the adult does not appear to be the child's guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware that they are accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (that is, a previous objection by the parent to that person exercising any authority in relation to the child). This does not apply to children in statutory out-of-home care or detention who have an appointed authorised carer (see below).

## 8.9. What if the Minor is in out-of-home care or in detention?

Children in statutory out-of-home care or detention are in the parental responsibility of the Minister for Families, Communities and Disability Services and day-to-day care responsibility lies with the authorised carer. The term 'authorised carer' is defined in section 137 of the *Children and Young Persons (Care and Protection) Act 1998.*

The authorised carer has authority under the *Children and Young Persons (Care and Protection) Act 1998* to consent to medical treatment not involving surgery on the advice of a Medical Practitioner. This ensures that children and young people in out-of-home care can receive appropriate and timely day to day medical and dental treatments. The authorised carer is not able to delegate their responsibility for consenting to medical treatment to anther adult.

Minors detained in a detention centre can be treated in the absence of consent in certain circumstances under section 27 of the *Children (Detention Centres) Act 1987.*

### Further guidance

- Department of Communities and Justice Factsheet *Consent for Medical and Dental Treatment of Children and Young Persons in out-of-home care*
- Department of Communities and Justice *Medical and Dental Consent Tool*

## 8.10. Can a Mature Minor make a valid Advance Care Directive?

Unlike an ACD written by an adult with capacity, an ACD written by a Mature Minor will not necessarily be legally binding. An ACD written by a Mature Minor will be treated in the same way that a Mature Minor's consent or refusal is treated – that is, it may be overridden by parents, or the court, if to do so would be in the best interests of the Minor.

In some circumstances, where a Mature Minor has prepared a written ACD, it may be appropriate to obtain a court order specifying whether the ACD must be followed.

## 8.11. What are the legal requirements for Special Medical Treatment in relation to children?

The *Children and Young Persons (Care and Protection) Act 1998* classes some procedures as Special Medical Treatment. It is an offence to carry out these procedures/treatments on a child less than 16-years-old unless:

- the treatment is required as a matter of urgency to save the child's life or to prevent serious damage to the child's health, or
- the treatment is described in paragraphs (a) or (b) below, and the Guardianship Division of NCAT has consented to the treatment.

The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* is different from that which is used under the *Guardianship Act*. The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* includes the following:

(a) any procedure or treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person unless the treatment is intended to remediate a life-threatening condition and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence
(b) any medical treatment in the nature of a vasectomy or tubal occlusion
(c) any medical treatment that involves the administration of a drug of addiction within the meaning of the *Poisons and Therapeutic Goods Act 1966* over a period or periods totalling more than 10 days in any period of 30 days, except for medical treatment in circumstances where the drug is administered in accordance with a written exemption granted, either generally or in a particular case, by the Secretary of the Department of Communities and Justice on the written request of the Secretary of the Ministry of Health
(d) any medical treatment that involves an experimental procedure that does not conform to the document entitled *National Statement on Ethical Conduct in Human Research 2007* published by the National Health and Medical Research Council in 2007 and updated in 2018.

### Further guidance

- Department of Communities and Justice *General Exemption*
- NSW Civil and Administrative Tribunal Guardianship Division Special Medical Treatment for people under 16 years

## 8.12. Consent requirements for gender affirming medical treatments for Minors (young people under 18 years old)

This section outlines the specific consent requirements for gender affirming medical treatments (GAMT) for young people under the age of 18 diagnosed with gender dysphoria as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)[1].

These consent requirements are distinct from and additional to the general consent requirements for minors as set out earlier in this chapter. Consent for GAMT for young people under the age of 18 is an evolving area of law.

GAMT refers to puberty suppression treatment (such as GnRH analogue therapy) and gender affirming (sex) hormone treatment. It does not include non-pharmacological interventions, such as psychosocial support.

This section is intended to support the Statewide Specialist Trans and Gender Diverse Health Service (the TGD Health Service) in relation to consent for young people under 18 years old.

Gender affirming surgical treatment is not within the scope of the TGD Health Service. Gender affirming surgery is generally not provided to people under 18 years old in NSW public hospitals.

This section does not cover consent for medical treatment for innate variations of sex characteristics (specifically, anatomical, chromosomal and hormonal characteristics people are born with that are different from medical and conventional understandings of female and male bodies – otherwise known as 'intersex').

### 8.12.1 Diagnosis and assessments to access GAMT

For young people aged under 18 years old, accessing GAMT requires:

- assessment by a multidisciplinary team
- diagnosis of gender dysphoria; **and**
- fulfilment of consent requirements.

This section only addresses the consent requirements. The general assessment and diagnosis requirements are outlined in the *Framework for the Specialist Transgender and Gender Diverse Health Service for People Under 25 Years* (the Framework)[2]. The Framework provides further information on the clinical pathway for the TGD Health Service, which includes GAMT.

### 8.12.2 Consent requirements for people under age 18 to access GAMT

#### (a) General Principles

- There are currently specific consent requirements for young people to access GAMT and health practitioners should engage in early discussions with parents/those who hold parental responsibility and the child about these requirements.
- Careful documentation of discussions with the parents and young person is required, including discussion of benefits, risks and any long-term side-effects, and sequelae of treatment as is currently known.
- Consent must be in writing on an approved NSW Health consent form.

#### (b) Parental Consent

Unless a court order has been made, NSW Health requires written consent from parents or person/s with parental responsibility prior to the commencement of GAMT if the young person is under 18 years old. However, written consent may not be required from *all* parents or persons with parental responsibility, as discussed at section 8.12.2 (d) and (e) of this Manual.

1 Clinical guidance recommends diagnosis of gender dysphoria as defined by the DSM-5-TR or Gender Incongruence under ICD-11.

2 Recommended clinical guidance includes - Framework for the Specialist Transgender and Gender Diverse Health Service for People Under 25 Years, Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, Australian Position Statement on hormonal management for adults, The Endocrine Society Clinical Practice Guidelines, Australian Informed Consent Standards of Care for Commencing and Managing Gender Affirming Hormone Therapy and World Professional Association for Transgender Health - Standards of Care for the Health of Transgender and Gender Diverse People.

Australian case law has established that GAMT may commence, without a court order, where there is no dispute or controversy between the child, treating clinicians and the parent/s (or persons with legal parental responsibility) about the proposed GAMT.

Additional requirements apply in cases involving Special Medical Treatment, discussed at section 8.12.2 (h) of this Manual.

However, where there is any dispute or controversy about the proposed GAMT, a court order is required before commencing treatment.

Where there are 2 parents who retain parental responsibility and remain involved with the child, clinicians must ascertain that both parents agree to the proposed GAMT and there is no dispute or controversy.

Australian case law also establishes that, in the absence of any dispute or controversy, any one person with parental responsibility can consent to GAMT treatment on behalf of the child. Therefore, clinicians can rely on the written consent of one parent, **however** they must confirm that there is no disagreement between the parents regarding the treatment. If there is a disagreement, a court order is required.

### (c) Where there is an absent parent who retains parental responsibility

Where a parent is absent or not involved in a child's life, they legally retain parental responsibility unless there is a court order removing it.

Although this is a developing area of the law, Australian case law indicates that, in cases involving an absent or largely absent parent who retains parental responsibility, the absence or lack of positive consent from the absent parent does not of itself indicate a dispute or controversy requiring a court order.

A 'dispute' or 'controversy' requires some indication that the absent parent might, in fact, disagree with the proposed GAMT.

Whether there is an indication that an absent parent will disagree needs to be determined in each case.

Where a parent is entirely absent, and has been for a significant period of time, it may be difficult to establish if there is a 'dispute' or 'controversy' requiring a court order.

If there is any indication at all that the absent parent may not agree with the proposed GAMT, the prudent approach is to assume there is a dispute or controversy and a court order will be required before commencing GAMT.

### (d) When is it appropriate to make inquiries about the absent parent's views?

In many scenarios, it will be appropriate for the clinicians to make inquiries of an absent parent to satisfy the treating team that the parent is in fact entirely absent and/or there is otherwise no dispute or controversy. This is consistent with the new section 61CA of the *Family Law Act 1975* (Commonwealth), which provides that parents are 'encouraged' to 'consult' each other about 'major long-term issues' pertaining to the child's health, where it is safe to do so.

However, in some cases it will not be appropriate to seek out the absent parent's views, including where it is clear they are entirely absent from the child's life. Additionally, there may be other considerations, such as a history of domestic or family violence, suggesting that it is not in the child's best interests to seek out the absent parent's views.

Where treating clinicians are considering commencing GAMT without confirming an absent parent's views, they should satisfy themselves that the other parent is, in fact, completely absent/uninvolved in the child's life and has been for a significant period of time.

If the parent is *not* entirely absent, but there is some reason why making inquiries would be inappropriate, then it may be necessary to seek a court order.

Clinicians must consider whether to attempt to contact an absent parent on a case-by-case basis and carefully document their reasoning if they decide not to attempt to seek an absent parent's views.

If there is any doubt about whether an absent parent's views should be sought, seek advice from the Ministry of Health, Legal and Regulatory Services Branch (nswh-legalmail@health.nsw.gov.au).

### (e) Other circumstances where there is no requirement to seek the views of a parent

When there is a current, valid court order allocating parental responsibility for medical treatment to one parent, or to any other person, to the exclusion of one parent or both parents, the TGD Health Service can rely on the consent of the person retaining parental responsibility. In such cases, there is no requirement to inquire as to the other parent's views. Also, the TGD Health Service should obtain a copy of the court order.

In some cases, the Minister for Families and Communities holds parental responsibility for young people (including young people in Out of Home Care (**OOHC**)). The Minister/Minister's delegate must consent to the proposed treatment before it commences.

Where a court has declared that the consent of only one parent (or some particular person) is required for GAMT or medical treatment generally and there is a copy of that court order provided to the TGD Health Service, no other parent's consent is required.

Where one parent is deceased, the surviving parent may give consent. The TGD Health Service should obtain a copy of the death certificate.

If there is any doubt regarding the interpretation of court orders, seek advice from the Ministry of Health, Legal and Regulatory Services Branch (nswh-legalmail@health.nsw.gov.au).

### (f) Young person's agreement or consent

Where the young person **is** assessed to be *Gillick* competent they must also provide written consent.

A *Gillick* competent child's consent will be sufficient for GAMT to be given, without a court order, in cases where there is no dispute between the child, parents and treating team (excluding cases involving Special Medical Treatment, discussed at section 8.12.2 (h) of this Manual).

However, it will ordinarily be necessary to obtain the parents' views to confirm that there is no dispute and, for this reason, the appropriate course is to obtain consent from the parents as well as the child. However, it will not be necessary to obtain consent from a parent who is absent or from whom consent need not be sought for the reasons discussed at section 8.12.2 (d) and (e) of this Manual.

See section 8.3 for guidance on assessing *Gillick* competence – essentially, a young person is *Gillick* competent when they have sufficient maturity and intelligence to fully understand the nature, complexity, advantages, disadvantages, known short-term and long-term side-effects and sequelae of the specific proposed treatment. They must also understand that there may be unknown sequelae.

Where the young person **is not** assessed to be *Gillick* competent:

- their parents can still lawfully consent to the treatment (in the absence of any disagreement between the parents and/or the treating team), and
- the health practitioner must still ensure the young person has a general understanding of the treatment and its effect, agrees to the treatment, and that this is documented.

**However,** where the young person **aged 16** years and above has a **cognitive impairment** such that they cannot understand the general nature and effect of the treatment, other authorisations may be necessary.

## Case Example 1 – Parental responsibility – absent parent

Harry is a 12-year-old who has been assessed as eligible and wishes to undergo puberty suppression treatment.

Harry is not Gillick competent but has a general understanding of and agrees with the treatment. Harry has a supporting parent who consents to the treatment and the clinicians all agree on the proposed treatment.

Harry's other parent lives in New Zealand and has not been involved in Harry's life for the past 4 years. There is no parenting order under the Family Law Act 1975 (Cth) allocating sole parental responsibility to the supporting parent. Additionally, there is a history of family violence. Harry's supporting parent has contacted Harry's other parent, but that other parent has not consented to the treatment and refuses to engage in any discussions.

**Question:** Is the supporting parent's consent sufficient?

**Answer:** No. The parent living in New Zealand is 'absent' but only for 4 years and still retains parental responsibility. There is also a history of family violence. Whilst the absent parent has not provided positive consent to the treatment, they refuse to engage.

Because of the history of family violence, it may not be in the best interests of the child to contact the absent parent. However, because the absent parent is contactable, and because the absent parent has in fact been contacted and has not provided consent, the treating team cannot satisfy itself that there is no dispute. Accordingly, it would be prudent not to commence treatment without a court order.

## Case Example 2 – Parental responsibility – absent parent

Billie is a 14-year-old who has been assessed as eligible and wishes to commence puberty suppression treatment. Billie is not *Gillick* competent. Billie's mother has consented to the treatment. Billie's biological father has had no involvement with Billie since infancy. Billie's mother left Billie's father when Billie was a few months old due to domestic and family violence, as well as drug and alcohol issues.

When Billie was 12 months old, the father commenced legal action to enable him to contact Billie, but did not pursue this and has since moved interstate. There has been no contact between the father and Billie's mother for 12 years but there is no parenting order under the *Family Law Act 1975* (Cth) allocating sole parental responsibility to the mother. The mother is extremely hesitant to seek the father out now and remains concerned for her and Billie's physical and psychological safety if she were to contact the father.

**Question**: Is the mother's consent sufficient?

**Answer:** Yes. The father is entirely absent and has had no involvement with Billie since infancy. There is nothing to suggest the existence of a dispute.

It would also not be in the child's best interests to attempt to seek out the father's involvement given the history of domestic and family violence. The mother's consent is sufficient and assuming the mother, child and treating clinicians agree, treatment can commence without the need to seek out the father's views or for a court order.

## Case Example 3 – Out of Home Care

Charlie is a 16-year-old in Out of Home Care who is *Gillick* competent. The Minister for Families and Communities holds parental responsibility. Charlie wishes to commence gender affirming (sex) hormone treatment and has been assessed as eligible.

Charlie's foster carers support the treatment. However, the biological parents have expressed their views that they would not consent to the proposed treatment.

The treating clinicians all agree with the proposed treatment plan and there is no disagreement amongst the treating team about diagnosis or treatment.

**Question:** Who provides consent for treatment?

**Answer:** Charlie must consent and the Minister for Families and Communities/Minister's delegate must also agree with the proposed treatment (such that there must be no dispute). If that consent and agreement is obtained, the treatment may proceed despite the lack of support by the biological parents as they do not have parental responsibility for Charlie.

| Case Example 4 – Parental responsibility – sole parental responsibility |
|---|
| Alex is a 17-year-old wishing to undergo gender affirming (sex) hormone treatment. Alex is *Gillick* competent and their supporting parent consents to the treatment. However, Alex's other parent is not involved and the Children's Court NSW made an order allocating sole parental responsibility to the supporting parent at the exclusion of the other parent until Alex is 18 years of age. |
| **Question:** Who provides consent for treatment?<br><br>Answer: Alex must consent and their supporting parent must also agree. As the Children's Court NSW order grants sole parental responsibility to the supporting parent, only the supporting parent's consent is required. It is not necessary to seek the views or consent of the parent whose parental responsibility has been removed by order of the Children's Court NSW.<br><br>If there is any doubt regarding the interpretation of the court orders, seek advice from the Ministry of Health, Legal and Regulatory Services Branch (nswh-legalmail@health.nsw.gov.au). |

### (g) Federal Circuit and Family Court of Australia Approval

An application to the Federal Circuit and Family Court of Australia is **mandatory prior to commencement of GAMT** where:

- There is **any dispute or controversy** between the child, the parents or persons with parental responsibility, or the treating clinicians about:
  - the child's *Gillick* competence to consent (if applicable)
  - the diagnosis of gender dysphoria or,
  - the proposed treatment.

(Rule 1.11 of the *Federal Circuit and Family Court of Australia (Family Law) Rules 2021*)

It is ordinarily the responsibility of the family to make the application to Federal Circuit and Family Court of Australia where it is required. However, staff from the TGD Health Service team may be asked to assist the Court with evidence on diagnosis and treatment.

There are legal service providers who may be able to assist the family through this process (see section 8.12.3 of this Manual).

### (h) Special Medical Treatment / Special treatment

If gender affirming (sex) hormone treatment is intended or reasonably likely to result in permanent infertility, it will be considered 'special medical treatment' or 'special treatment', in which case additional considerations and authorisations are required.

The legal requirements are as follows:

**For a young person under the age of 16:**

'**Special Medical Treatment**' under section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (Care Act) includes treatment that is intended or reasonably likely to render the child permanently infertile *unless*:

- the treatment is intended to treat a life-threatening condition, and
- permanent infertility is an unwanted consequence of the treatment.

It is a criminal offence under section 175(1) for clinicians to administer 'Special Medical Treatment' without first obtaining the consent of the NSW Civil and Administrative Tribunal (**NCAT**), unless the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment to save the child's life or prevent serious damage to their health. This exception will not ordinarily be available in respect of GAMT.

For this reason, if the proposed GAMT is 'reasonably likely' to cause permanent infertility, NCAT consent is necessary before treatment can proceed. This is required regardless of whether the child and parent/s consent.

Before NCAT can consent, it must be satisfied that the proposed GAMT is necessary to save the child's life or prevent serious damage to the child's psychological or physical health (section 175(3)) and that the treatment is in the child's best interests.

- **Meaning of 'reasonably likely' to cause permanent infertility**

  Recent NCAT cases have determined that medical treatment that is 'reasonably likely' to have the effect of rendering a person permanently infertile is 'treatment that creates a real, not speculative or remote, but not probable risk of permanent infertility for the treated person'.

  It is not necessary that the permanent infertility occurs before age 16 – there must be a realistic and holistic assessment of the proposed treatment, including beyond the age of 16.

  Whether or not there is a 'real, not speculative or remote' risk of permanent infertility will require the treating team to form an opinion on a case-by-case basis.

  This is an evolving area of medicine and further evidence is required on the fertility risks for children who commence puberty suppression early and proceed to gender affirming hormone treatment.

  Clinicians should remain aware of any new evidence in this respect and make their own clinical determination as to whether the proposed treatment is 'reasonably likely' to cause permanent infertility. This may require referring the child to a fertility specialist for an independent opinion.

- **Clinicians should consider the following before deciding whether to apply to NCAT:**
  - Is the clinician of the opinion that the treatment is 'reasonably likely' to cause permanent infertility – what evidence is there?
  - Is the treatment necessary to save the child's life or prevent serious psychological or physical harm if it is not administered before age 16 – what evidence is there?
  - How long does the child need to wait until they are age 16 when NCAT consent is not necessary?
  - What are the risks to the child's psychological and physical well-being in waiting – solid, contemporaneous psychological and/or medical evidence will be required to satisfy NCAT that the child cannot wait until age 16.
  - See section 8.11 of this Manual for further guidance.
  - See NCAT Fact Sheet for Special Medical Treatment for people under 16.

**Any NCAT application is to be made by the Health Service/Local Health District with clinicians providing supporting evidence.**

**For a young person over the age of 16 who is incapable of understanding the general nature and effect of the proposed treatment or cannot communicate consent:**

- '**Special Treatment**' under section 33 of the *Guardianship Act 1987* (NSW) [Guardianship Act] includes treatment that is intended or reasonably likely to render the person permanently infertile.
  - An application to NCAT is necessary where the young person over 16 years old, is incapable of providing consent and the GAMT is reasonably likely to cause permanent infertility.
  - This does not apply for a young person over the age of 16 who is capable of understanding the general nature of the proposed treatment and of indicating whether or not they consent to the treatment being carried out (whether or not *Gillick* competent).
  - It is a criminal offence under section 35 of the Guardianship Act for clinicians to administer 'Special Treatment' unless NCAT provides consent or the treatment is carried out in accordance with an order of the Supreme Court of NSW.
  - NCAT can only consent to Special Treatment if it is satisfied that the treatment is necessary to save the person's life or prevent serious damage to their health (section 45(2) of the Guardianship Act).
  - NCAT will also have regard to the views of the young person, clinicians, persons responsible and the best interests of the young person.

- **Clinicians will need to:**
  - determine that the GAMT will be 'reasonably likely' to cause permanent infertility (see guidance above in relation to Special Medical Treatment)
  - provide NCAT with evidence to support that the treatment is necessary to save the person's life or prevent serious damage to their health.
  - contact the Ministry of Health's Legal and Regulatory Services Branch to determine whether an application to the Supreme Court of NSW, rather than NCAT should be made. This is particularly important when it is difficult to determine if the treatment is necessary to save the person's life or prevent serious damage to their health.
  - See section 7.8 of this Manual for further guidance on Special Treatment.
  - See NCAT Fact Sheet for Special Treatment.
- **Any NCAT application is to be made by the Health Service/Local Health District with clinicians providing supporting evidence.**

**Case Example 5 – Court or NCAT applications**

Jackie is a 15-year-old transgender female who wishes to commence gender affirming oestrogen hormone treatment. Jackie is assessed as *Gillick* competent and Jackie's parents both consent to the treatment. The clinicians also all agree with the treatment.

As Jackie is 15 years old, the clinicians need to consider whether the treatment is reasonably likely to cause permanent infertility.

**Questions**: Is an application to the Federal Circuit and Family Court of Australia required? Is an application to NCAT required?

**Answer:** As there is no dispute or controversy about *Gillick* competence, consent or the proposed treatment, an application to the Federal Circuit and Family Court of Australia is not required.

However, as Jackie is under the age of 16, clinicians need to determine if the proposed GAMT is 'reasonably likely' to cause permanent infertility and therefore falls within the meaning of 'Special Medical Treatment' under section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

This will be a case-by-case assessment based on current, available medical evidence.

If the clinicians form the view that the treatment will be reasonably likely to render Jackie permanently infertile, NCAT consent is necessary before commencing treatment.

Before deciding whether to apply to NCAT, clinicians will need to consider if they have sufficient evidence to satisfy NCAT that the treatment is necessary to save Jackie's life or prevent serious harm to Jackie's psychological or physical health, and that it is in Jackie's best interests to commence treatment before the age of 16.

If there is uncertainty regarding the legal requirements, please contact the Ministry of Health, Legal and Regulatory Services Branch (nswh-legalmail@health.nsw.gov.au).

### 8.12.3 Legal support for young people and family members

Families can access legal advice from Legal Aid NSW on 1300 888 529 or non-government organisations, such as Justice Connect.

The Inner City Legal Centre (ICLC) Trans and Gender Diverse Legal Service can also provide free specialist legal advice to families making an application to NCAT or the Federal Circuit and Family Court of Australia. ICLC can be contacted on 02 9332 1966 or iclc@iclc.org.au.

### 8.12.4 Further advice

Legal advice from the Ministry of Health, Legal and Regulatory Services Branch can be sought if there is uncertainty about consent for GAMT and/or the need for NCAT or Federal Circuit and Family Court of Australia consent in the circumstances of an individual case. Please email nswh-legalmail@health.nsw.gov.au if you require any legal advice in relation to this section of the Manual.