Gender Recognition Act 2004 reform and young people: Rights, capacity and welfare

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Introduction
This paper examines issues raised by proposed changes to the Gender Recognition Act 2004 (GRA) in Scotland in relation to young people up to the age of 18 years.

The GRA allows adults aged 18 years or over to obtain a Gender Recognition Certificate (GRC) which changes the ‘legal sex’ on their birth certificate from male to female, or vice-versa. Obtaining a GRC requires a psychological diagnosis of gender dysphoria, evidence of having lived for at least 2 years in the person’s ‘acquired gender’ (a panel assesses paperwork provided in each case: applicants are not called to interview), a statutory declaration of intention to continue in the acquired gender until death and a fee of £140. A report of medical treatment is also needed, but there is no legal requirement to have had surgical intervention or other physical interventions: in this respect the GRA was seen at the time as world-leading. The Act also provides privacy protections making it unlawful for officials to reveal someone has reassigned their legal sex in some circumstances (s.22 (1)).

In response to criticism that the process of obtaining a GRC is overly bureaucratic and medicalised, both the Scottish and UK Governments have proposed that individuals should be allowed to change legal sex based on self-declaration alone. The Scottish Government proposes to reduce the minimum age of application for a GRC to 16 years, in line with the age at which young people acquire several other rights. The Scottish Government has also asked for views on what arrangements should be put in place for those under 16 years.


The paper concludes that it is currently not clear whether formal recognition of gender identity by the state from the age of 16 is in the best interests of young people, and that greater emphasis should be placed on welfare principles.

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1. A rights-based approach to gender identity: principles and practice

- The relationship between gender identity, the GRA proposals put forward by Scottish Government, and a rights-based approach to young people and children is complex.
- Some organisations already allow male-bodied people to access female single-sex services, including those used by young women and girls. Some academics argue that current proposals to relax the conditions for obtaining a GRC would increase the number of male-bodied people with access to female single-sex spaces, and may make it harder to question or refuse access.
- The Scottish Government needs to respond in detail to these concerns, and clearly explain how the rights of young people and children will be protected.

1.1. A rights-based approach to gender identity

From a rights perspective, several human rights instruments are relevant to the legal recognition of gender identity among young people (see further: CYPCS 2018). While gender identity is not addressed in the United Nations Convention on the Rights of the Child (UNCRC), relevant Articles include: 3 (best interests of the child); 6 (supported to live and grow); 8 (right to preserve identity); 12 (children views given due weight in accordance with age and maturity); 14 (right to own thoughts and beliefs) and 16 (right to privacy). The Yogyakarta Principles (31) explicitly support access to legal recognition for gender identity, although these are not recognised in international law.

1.2. Translating principles into practice

In practice, the relationship between gender identity and a rights-based approach to young people is complex, and involves competing rights between different groups.

In a domestic setting, this relates principally to the Equality Act 2010 (EqA), which protects certain groups from disadvantage or unfair treatment in England, Wales and Scotland. Eight single-sex exemptions in the EqA allow employers, service providers, associations and charities to provide single-sex or separate sex services for a range of reasons, and to exclude people of the opposite sex. A person’s legal sex for the purpose of the EqA is as stated on their birth certificate, which is biological sex, unless changed via a GRC (as clarified by the EHRC in July 2018). Provided it is a proportionate means to a legitimate end, a person can also be excluded from single-sex or separate sex services on the basis of being transsexual, even if they share the same legal sex as other participants.

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3 Sex refers to legal sex, as stated on a current birth certificate. Gender reassignment in the EqA is broadly drawn as anyone who is ‘proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person’s sex by changing physiological or other attributes’.
4 The nine protected characteristics in the EqA (s.4) are: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race and sex.
5 These are: single-sex services (e.g. cervical smears or changing rooms); occupational requirements (e.g. working with rape victims); communal accommodation (e.g. dormitories); sporting competitions where sex is a factor; charities aimed at benefitting people with a given protected characteristic; single-characteristic associations and clubs; and women-only shortlists (e.g. single-sex shortlists for election candidates). Separate regulations also require single-sex accommodation, toilets and changing facilities in schools.
6 The example given in the Act is a counselling group for female victims of sexual assault. It would be legal to exclude a male-to-female transsexual if their presence would make women unlikely to attend.
Opinion remains divided on how the EqA should and does translate into practice. Despite the single-sex protections available to service-providers, many organisations in Scotland and the UK already allow male-bodied individuals to access female single-sex spaces on the basis of ‘gender identity’, including those used by young women and girls, which raises the issue of competing rights. These include hospitals, the Girl Guides (including sleeping arrangements); Topshop (changing rooms); and the Youth Hostel Association.

Tension around competing rights, including those of parent/carers, are evident in the LGBT Youth Scotland/Scottish Trans Alliance guidance for supporting trans school children. While endorsed by many Scottish local authorities, this effectively advises that primary and secondary schools bypass the single-sex protections set out in the EqA (for a detailed Children’s Rights Impact Assessment see: Women and Girls in Scotland, 2018). For example, the guidance states: ‘if a learner feels uncomfortable sharing facilities with a transgender young person, they can be allowed to use a private facility such as an accessible toilet, or to get changed after the trans young person is done’. In relation to residential trips, it is advised that there is no reason for parents/carers to be informed if a transgender young person is sharing a room with their peers (2018: 18, 21).

While some organisations, including Scottish Women’s Aid and Rape Crisis Scotland, take the formal position that access to their services should not be limited to those who are legally female, there is a wider lack of legal clarity on how the EqA single-sex exemptions should be applied (Monaghan, 2018).

Against this complex landscape, some academics and women’s groups have argued that proposals to relax the conditions for obtaining a GRC will increase the number of male-bodied people with access to single-sex spaces, and may make it harder to query or refuse access (Norman, 2018, Komorowski, 2018). Academics and women’s groups have also expressed concern over influential organisations lobbying for the removal of single-sex exemptions, including the Scottish Trans Alliance (2015: 2) and Stonewall (2017). Other academics argue that GRA reform will not affect the existing rights of natal women and girls, and the status quo will be retained, which is not viewed as problematic (Sharpe, 2018, Whittle, 2018).

Taken together, these observations suggest the Scottish Government needs to respond in detail to concerns that its GRA proposals will make it harder to uphold single-sex spaces, and clearly explain how the rights of young people will be protected.

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2. Young people’s rights, capacity and welfare

- The number of young people and children seeking support from gender services has increased in the last five years, particularly among natal girls.
- Young people from the most deprived areas according to the Scottish Index of Multiple Deprivation (SIMD) are over-represented among those referred to the Sandyford Gender Identity clinic in Glasgow.
- Practitioners have observed an increase in referrals of individuals with complex presentations or autistic-spectrum disorders.
- The causes of gender-dysphoria, as well as the recent increase in referrals are not known, although some academics and practitioners argue there is evidence of ‘social contagion’ and/or socio-cultural effects.
- There is no method to accurately predict future gender-identity, although it is clear not all trans or gender-questioning young people and children will persist into adulthood.
- Removing medical gatekeeping to the GRC process may result in more requests for medical and surgical interventions, from which not all individuals will benefit.
- There is no medical consensus on the longer-term impact of medical interventions such as puberty blockers and hormone treatments. This raises questions as to whether it is possible for individuals to provide genuinely informed consent to such treatment.
- While the case for self-declaration of legal sex for young people has been largely framed in terms of rights, the points outlined above raise welfare and safeguarding concerns. These should be robustly reviewed ahead of any legal reform.
- In terms of immediate next steps, it is suggested the Scottish Government undertake a full Equality Impact Assessment and a Child Rights and Wellbeing Impact Assessment on its proposals, ahead of any legislative steps.

2.1. Setting the age limit for self-declaration of legal sex

The Scottish Government believes setting the age limit for the sex self-declaration of legal sex at 16 years would be consistent with the age at which young people can exercise other rights under the law in Scotland. For example, 16 and 17-year olds may get married or enter a civil partnership; record a change of name; and vote in Scottish elections without parental consent. The Age of Legal Capacity (Scotland) Act 1991 (s2.4) sets out children’s right to access and consent to medical treatment at 12 years and may go lower, providing the child ‘is capable of understanding the nature and possible consequences of the procedure or treatment’.

2.2. Balancing rights, capacity and welfare

On the question of balancing rights, capacity and welfare, UNCRC Article 5 states that direction and guidance provided by parents or others with responsibility for the child, must account for the ‘evolving capacities of the child’ to exercise rights on his or her own behalf. This recognises there is a balance to be struck between the increasing capacity of young people to hold views and take positions, and the protective role of parents/carers. In

Scotland, parents have a legal responsibility to safeguard and promote their child’s health, development and welfare under the Children’s Scotland Act 1995 (s1a).

While the case for the self-declaration of legal sex for 16-year olds has largely been framed in terms of rights, the recent increase in the number of young people seeking support from gender identity services, particularly natal girls, together with a lack of medical consensus on the medium to longer-term impact of medical intervention, suggests the Scottish Government should now place greater emphasis on welfare and safeguarding principles. The remainder of this paper examines these points in more detail.

2.3. Recent trends: Scotland and England

Gender dysphoria refers to the distress that a person can experience because they feel a mismatch between their biological sex and their felt gender identity. Note however that not all young people referred to gender services are necessarily distressed.

In Scotland, the number of young people and children aged 17 years or under seeking support from the Young Peoples Gender Identity clinic at Sandyford in Glasgow increased by 450% from 2013 to 2015: from 34 to 187 cases (Scottish Government 2017: 132 para. 3.4).16

In England, referrals to the NHS Gender Identity Development Service (GIDS) for children and young people up to the age of 18 years increased by more than 2,000% from 2009/10 to 2017/18: from 97 to 2,519 cases. Table 1 shows this trend:

<table>
<thead>
<tr>
<th>Year</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>97</td>
</tr>
<tr>
<td>2010/11</td>
<td>139</td>
</tr>
<tr>
<td>2011/12</td>
<td>208</td>
</tr>
<tr>
<td>2012/13</td>
<td>314</td>
</tr>
<tr>
<td>2013/14</td>
<td>468</td>
</tr>
<tr>
<td>2014/15</td>
<td>697</td>
</tr>
<tr>
<td>2015/16</td>
<td>1419</td>
</tr>
<tr>
<td>2016/17</td>
<td>2016</td>
</tr>
<tr>
<td>2017/18</td>
<td>2519</td>
</tr>
</tbody>
</table>

Sources: NHS Gender Identity and Development Service (GIDS)

While directly comparable data are not published in Scotland, Thomson et al. state ‘these percentage increases in referrals [to GIDS] are very similar to those experienced by the Sandyford Young Persons service, who saw a 103.2% increase from 2014 to 2015, and a 43.0% increase from 2015 to 2016’ (2018: 90).17

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2.4. Demographics: Scotland and England

Practitioners from clinical and voluntary organisations in Scotland have observed an increase in demand for gender services from younger adults (under 25-year olds) and pre-pubertal children (Thomson et al. 2018: 70).\(^{18}\)

The average age of referrals to the Sandyford clinic fell from 15.0 years to 13.8 years between 2014 and 2017. The mean age across this period was 14.1 years, with accepted referrals ranging from 6 to 16 years. The most frequent age of referral (mode) was 16 years (Thompson et al. 2018: 46).\(^{19}\)

Table 2 shows the age-distribution in referrals to GIDS (England) by age in 2017/18, with a marked increase in the teenage years, at which stage young people may be exploring their sense of self, and/or experiencing the psychological and emotional effects of puberty.

Table 2. Referrals to the NHS Gender Identity Development Service (GIDS) by age, 2017/18

![Graph showing age distribution of referrals to GIDS](image)

Source: NHS Gender Identity and Development Service (GIDS)
1. Fewer than 5 referrals were made for three and four-year olds, respectively (not shown)
2. All referrals for those 18 years or over were rejected on age grounds

In Scotland, young people from the most deprived Scottish Index of Multiple Deprivation (SIMD) are over-represented among referrals to the Sandyford clinic (Thomson et al. 2018: 47).\(^{20}\)

Practitioners in Scotland have also observed an increase in referrals of individuals with complex presentations or autistic-spectrum disorders (Thomson et al. 2018: 71).\(^{21}\) This is supported by research from other jurisdictions on the mental health of gender-dysphoric adolescents which indicates a higher risk of other co-existing difficulties, compared to the general adolescent population (Strang et al. 2016),\(^{22}\) and a higher risk of autistic-spectrum conditions (GIDS online).\(^{23}\)

\(^{18}\) See note 17.
\(^{19}\) See note 17.
\(^{20}\) See note 17.
\(^{21}\) See note 17.
\(^{23}\) Gender Identity Development Service (online) Evidence base: autistic-spectrum conditions.
2.5. Natal girls and young women

Referrals of natal girls to GIDS (England) increased by more than 4,000% from 2010 to 2017/18: from 40 to 1,806 referrals. In 2017/18, natal girls accounted for 72% of referrals to GIDS. Figure 3 shows GIDS data from 2009/10 to 2015/16, and the increasing proportion of referrals from natal girls, compared to natal boys.

Table 3. Referrals to the NHS Gender Identity Development Service (GIDS) by natal sex, 2009/10 to 2015/16

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>56</td>
<td>40</td>
</tr>
<tr>
<td>2010/11</td>
<td>72</td>
<td>65</td>
</tr>
<tr>
<td>2011/12</td>
<td>88</td>
<td>118</td>
</tr>
<tr>
<td>2012/13</td>
<td>121</td>
<td>188</td>
</tr>
<tr>
<td>2013/14</td>
<td>188</td>
<td>278</td>
</tr>
<tr>
<td>2014/15</td>
<td>270</td>
<td>427</td>
</tr>
<tr>
<td>2015/16</td>
<td>490</td>
<td>929</td>
</tr>
</tbody>
</table>

Source: Gender Identity Development Service statistics

While comparable disaggregated data are not published in Scotland, practitioners also describe an increase in referrals of natal girls, particularly in younger age-groups (Thomson et al. 2018: 70).

This uneven sex-distribution is also evident in Canada, the United States, Finland and the Netherlands (Marchino, 2017). Research from Finland shows the over-representation of complex adolescent females presenting at gender clinics (Kalatiala-Heino et al., 2015).

These differences raise questions about the gendered life-experiences of natal girls, which require further investigation. For example, Marchiano (2016) suggests transgender identity may be a way for adolescent natal girls to express feelings of discomfort with their bodies. UK Equalities Minister Penny Mordaunt has recently requested a study to investigate this increase.

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24 See GIDS: Gender Identity Development Service statistics (undated); GIDS referrals increase slows in 2016/17 (2017).
25 See note 17.
28 Times (2018) Minister Penny Mordaunt orders research into rise of gender referrals for girls. 17 September 2018,
2.6. Risks and gaps in the evidence-base

The recent increase in gender-dysphoria referrals is not well understood, although some academics and practitioners suggest there is evidence of 'social contagion' and/or socio-cultural effects. Drawing on parental reports, Littman (2018)\(^\text{29}\) describes how the 'onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe.' Littman also notes parents reported an increase in social media/internet use prior to disclosure of a transgender identity. From a GIDS practitioner perspective, Midgen states:

"It is logical to infer that some of the children and young people we see in GIDS will grow into adults whose gender dysphoria is such that the only reasonable 'solution' or treatment is a social role transition followed by medical intervention. However, it is [my experience] that the current socio-cultural situation is one which has permitted an inflation of the idea, and that we are indeed co-creating the very notion of the 'trans kid'." (2018: 141)\(^\text{30}\)

These trends have prompted concerns that insufficient consideration has been given to the potential consequences of removing medical input from the process of acquiring a GRC. For example, Byng et al. suggest that removing medical gatekeeping will likely lead to more medicalisation, while weakening existing safeguards:

- It is likely more people will request and undergo medical interventions such as cross-sex hormones and surgical interventions, and that some individuals will not benefit.
- Self-declaration of legal sex may lead to a neglect of the wider reasons a person wishes to transition, which are often unconscious and need time to emerge.
- Current clinical assessments provide some safeguards for identifying those whose request for transition is linked to underlying mental health problems or neurodevelopmental (e.g. autistic) traits (Byng et al. 2018a).\(^\text{31}\)

There is a lack of medical consensus on the impact of interventions such as puberty blockers (available from early puberty) and cross-sex hormone treatments (from 16 years). Byng et al. (2018b)\(^\text{32}\) state that the evidence on the medium-term benefits of hormonal treatment and puberty blockers is based on weak follow-up studies. The NHS Scotland Gender Reassignment Protocol (2012)\(^\text{33}\) also acknowledges that ‘there is limited data on the long-term health risks of hormone treatment and patients should be made aware of the risks and the importance of long-term monitoring’. Richards et al. argue puberty blockers are ‘being used in the context of profound scientific ignorance’, given that the ‘causes of

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[gender-dysphoria] are largely unknown as are the reasons for its rapidly changing epidemiology’ (2018).34

A group of North American endocrinologists describe the health consequences of gender-affirmative therapy as detrimental: ‘Children and adolescents with questions about their gender are increasingly being given life-altering, irreversible hormones and surgery which can lead to increased risk of death from cardio-vascular disease, life threatening blood clots, permanent sterility, and sexual dysfunction, among other problems’ (Laidlaw et al. 2019).35 Given the current gaps in the medical evidence, the authors question whether a child, adolescent or parent can provide genuine informed consent to such treatment. In England, there is evidence to suggest that some NHS Trusts have allowed the rights of transgender children to override those of their parents even when the children are not ‘Gillick competent’36 (Telegraph, 2019).37

Laidlaw et al. (2018)38 state the diagnosis of gender dysphoria has no reliable testing method. There is also no method to accurately predict future gender-identity (Drucker 2013:14)39. Many children and young people who present with gender dysphoria do not persist into adulthood (Scottish Government 2018: 133 para. 4.2),40 although eventual outcomes may be influenced by medical intervention. For example, Richards et al. (2019)41 state the use of puberty blockers may prevent some young people from eventually becoming comfortable with their birth sex.

Research also indicates that some gender-questioning children who do not persist are more likely to later identify as gay or lesbian: ‘studies show that gender dysphoric feelings eventually desist for the majority of children with gender dysphoria, and that their psychosexual outcome is strongly associated with a lesbian, gay, or bisexual sexuality which does not require any medical intervention’ (Ristori et al. 2016: 18).42

36 Children under 16 years can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent (NHS Online: Children and young people. Consent to treatment).
37 Telegraph (2019) NHS staff being advised to ignore parents' wishes if children self-declare as different gender, guidance shows. 11 January 2019.
38 See note 35.
40 The Scottish Government state: ‘There is a limited evidence base about whether children will continue to experience these feelings in the longer term. Follow-up studies indicate overall that for 85.2% of the children, their distress discontinued either before or early in puberty. However, the rates in the individual studies varied widely’ (2018: 133: para. 4.2) (See note 16).
41 See note 34.
3. Conclusion

Current gaps in the medical evidence base mean that it is not clear whether formal recognition of a new gender identity by the state from the age of 16 would be in the best interests of young people. These gaps include: a lack of understanding as to the recent increase in young people seeking support from gender services, and the over-representation of natal girls; a lack of medical consensus on the medium to longer-term impact of medical intervention; and a limited understanding of persistence patterns. It is also unclear how the GRA reform proposals would impact on the practical operation of the EqA, especially given the variability in its current application.

These observations suggest that each of these areas should be robustly reviewed and risk-assessed ahead of any legislative steps, including input from independent medical practitioners. The Scottish Government should also fully explore and clarify issues around medical consent in a Scottish context.

In terms of immediate next steps, it is suggested the Scottish Government undertake a full Equality Impact Assessment and Child Rights and Wellbeing Impact Assessment on its GRA proposals. The Scottish Government should also ensure that resources are in place to provide appropriate support and care for young people and children who express distress about their gender identity.

More broadly, the evidence in this paper suggests that greater emphasis should now be placed on welfare, support and safeguarding principles.