

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.¹

This paper examines the Scottish Government GRA proposals in relation to young people. The paper is structured in two main parts as follows.

Part one looks at competing rights arguments, and the implications of self-declaration of legal sex on the existing rights of young people and children to access single-sex spaces under the Equality Act 2010. The analysis is intended to raise points for discussion that are relevant to all young people, and contribute to the wider debate on gender recognition reform. This part of the paper concludes that the Scottish Government needs to respond in detail to concerns that its GRA proposals will make it harder to uphold maintain single-sex spaces, and clearly explain how the rights of all young people will be protected.

Part two takes a different approach and focuses on welfare concerns in relation to transgender and gender-questioning children and young people. First, the report discusses the balance between the increasing or evolving capacity of young people to make decisions on issues affecting their lives, and the protective role and responsibilities of parents/carers. Parts 2.2 to 2.4 examine recent trends among young people and children seeking support for gender-identity issues, including a sharp rise in referrals to gender clinic services from natal girls and young women. Part 2.5 outlines risks and gaps in the current evidence-base

¹ Scottish Government (2018) [Review of Gender Recognition Act 2004](#). Factsheet.

around medical intervention, and notes concerns from some medical professionals that removing medical gatekeepers from the GRC application process may weaken existing safeguards and increase the likelihood of medical intervention.

The report concludes that current gaps in the 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. This includes a lack of clarity on how the GRA reform proposals would impact on the privacy rights of all young people under the Equality Act 2010.

There are also gaps in our understanding of recent trends in relation to transgender and gender-questioning young people and children, and in the current medical evidence-base. These issues need to be considered both in their own right, and in relation to GRA reform given that that some medical professionals have raised concerns over the risk of increased medicalisation should the proposed changes go ahead.

Overall, the evidence in the paper suggests that the Scottish Government needs to consider the rights and welfare needs of all children and young people in relation to its GRA proposals. To this end, it is suggested that the Scottish Government undertakes a full Equality Impact Assessment (EQIA) and Child Rights and Wellbeing Impact Assessment (CRWIA) on GRA reform ahead of any legislative steps. 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.

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

- The relationship between the GRA proposals put forward by Scottish Government, and a rights-based approach to young people and children is complex and involves competing rights between different groups. This complexity relates principally to the Equality Act 2010, which provides for single-sex or separate sex services and spaces for a range of reasons.
- 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

Several human rights instruments are relevant to the legal recognition of gender identity among young people (see further: CYPCS 2018).² 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.

² Children and Young People's Commissioner Scotland (2018) [Review of the Gender Recognition Act](#).

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.³

Equality Act 2010: sex and gender reassignment

The Equality Act identifies nine 'protected characteristics'.⁴ People with a protected characteristic are protected from direct and indirect discrimination, harassment and victimisation on the basis of having that characteristic.

Under [Section 11](#) 'sex' is a protected characteristic. This is the legal cornerstone of women's and girls' existing rights to fair treatment, and to privacy and dignity in services provided to them.

The EqA describes sex as being a man or a woman, and in [Section 212\(1\)](#), as a female or a male of any age. [EHRC guidance](#) states that sex is binary in UK law and determined by what is recorded on a birth certificate. For the vast majority of people, this is biological sex.

A trans person can change the legal sex on their birth certificate by obtaining a Gender Recognition Certificate (GRC) under the Gender Recognition Act 2004. There are currently around 5,000 people in the UK with a GRC, aged 18 years or over.

A trans person who does not have a GRC retains the sex recorded on their birth certificate for legal purposes.

Under [Section 7](#) gender reassignment is a protected characteristic, which is defined broadly 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 of sex'. This does not however change a person's legal sex, nor provide a general right of access to single-sex services and spaces.

The EqA permits organisations to discriminate on the basis on sex for a range of reasons, for example, to provide single-sex or separate sex services.⁵ This is the legal basis for most separate arrangements for women and men, and for boys and girls.

A trans woman who does not hold a GRC can be excluded from female-only services and spaces because they are legally male ([EHRC, 2018](#)).

Provided it is a proportionate means to a legitimate end, a transgender person with a GRC may also be excluded, even though they share the same legal sex as other participants.

The EqA [Explanatory Notes](#) give the following example: '*A counsellor working with victims of rape might have to be a woman and not a transsexual person, even if she has a Gender Recognition Certificate, in order to avoid causing them further distress.*'

See further: Freedman et al. (2019) [TIE letter: Legal response](#) (30 March 2019)

³ These are: age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race & sex.

⁴ MurrayBlackburnMackenzie (2019) [Biological sex is the legal cornerstone of women's rights to fair treatment](#). Holyrood magazine 11 March 2019.

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). In addition, specific regulations require single sex accommodation, toilets and changing facilities, for example in [schools](#).

Opinion remains divided on how the EqA should and does translate into practice. Despite the single-sex protections available to service-providers, many organisations 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 also 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 should 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](#)).⁶ 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).⁷

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 (see [Monaghan, 2018](#)).⁸

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](#),⁹ [Komorowski, 2018](#)).¹⁰

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)¹¹ and Stonewall (2017).¹² 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](#)).¹³

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

⁶ [Women and Girls in Scotland \(2019\) Children's Rights Impact Assessment: Supporting Transgender Young People in Scotland: guidance for schools in Scotland.](#)

⁷ [LGBT Youth Scotland/Scottish Trans alliance \(2018\) Supporting Transgender Young People: Guidance for Schools in Scotland.](#)

⁸ [Monaghan, K. \(2018\) HoC Women and Equalities Committee Oral evidence: Enforcing the Equality Act: the law and the role of the Equality and Human Rights Commission. HC 147031 October 2018.](#)

⁹ [Norman, J. \(2018\) Gender recognition, self-ID and next steps. Counsel Magazine.](#)

¹⁰ [Komorowski, J. \(2018\) UK Reform of Gender Recognition and the Commission for Equality and Human Rights. Oxford Human Rights Hub.](#)

¹¹ [Scottish Transgender Alliance \(2015\) Written evidence submitted by Scottish Transgender Alliance, Equality Network to the Transgender Equality Inquiry.](#)

¹² [Stonewall \(2017\) A Vision For Change: Acceptance without exception for trans people 2017-2022.](#)

¹³ [Sharpe, A. \(2018\) What would changes to the Gender Recognition Act mean? Two legal views. The Conversation; Whittle \(2018\) cited in The Guardian 'Shifting sands': six legal views on the transgender debate. 19 October 2018.](#)

Part 2. Young people's rights, capacity and welfare

- UNCRC Article 5 recognises there is a balance to be struck between the increasing capacity of young people to make decisions on issues affecting their lives, and the protective role of parents/carers.
- While the case for legal self-identification for young people has been largely framed in terms of rights, recent trends in referrals to gender identity services as well as gaps in the medical evidence-base also raise welfare considerations.
- The number of young people and children seeking support from gender services has increased sharply 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.
- Some practitioners have argued that removing the role of medical gatekeeping from 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.
- These observations suggest the Scottish Government needs to consider welfare as well as rights principles in relation to GRA reform, and ensure that appropriate resources are in place for transgender and gender-questioning children and young people.

2.1. Balancing rights, capacity and welfare

The Scottish Government believes that 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'.

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 that there is a balance to be struck between the increasing capacity of young people to make decisions on issues affecting their lives,

and the protective role of parents/carers.¹⁴ 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, as per UNCRC Article 5 this needs to be balanced with an appreciation of both capacity and welfare principles. From a welfare or protective perspective, particular consideration needs to be given to the sharp increase in young people seeking support from gender identity services, especially natal girls; concerns that the removal of medical input from the GRC process may weaken safeguards and result in increased medicalisation; and relatedly, a lack of professional consensus on the medium to longer-term impact of medical intervention. The remainder of this paper examines these points in more detail.

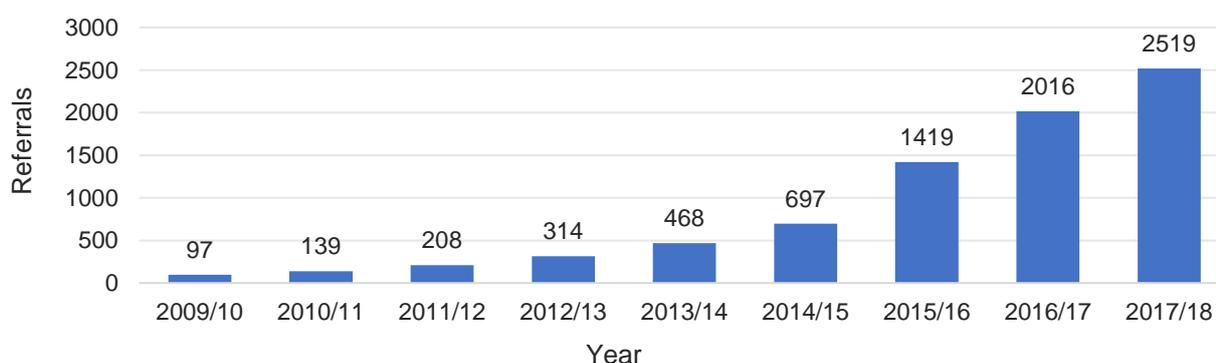
2.2. Recent trends: gender services referrals in Scotland and England (under 18s)

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).¹⁵

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 1. Referrals to the NHS Gender Identity Development Service (under 18s) 2009/10 - 2017/18



Sources: NHS Gender Identity and Development Service and Gender Identity Development Service statistics

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).¹⁶

¹⁴ Landsdown, G. (2005) *The evolving capacities of the child*. Unicef/Save the Children.

¹⁵ Scottish Government (2017) *Review of the Gender Recognition Act 2004: A Consultation*.

¹⁶ Thomson, R., Baker, J. and Arnot, J. (2018) *Scottish Public Health Network (ScotPHN) Health Care Needs Assessment of Gender Identity Services*.

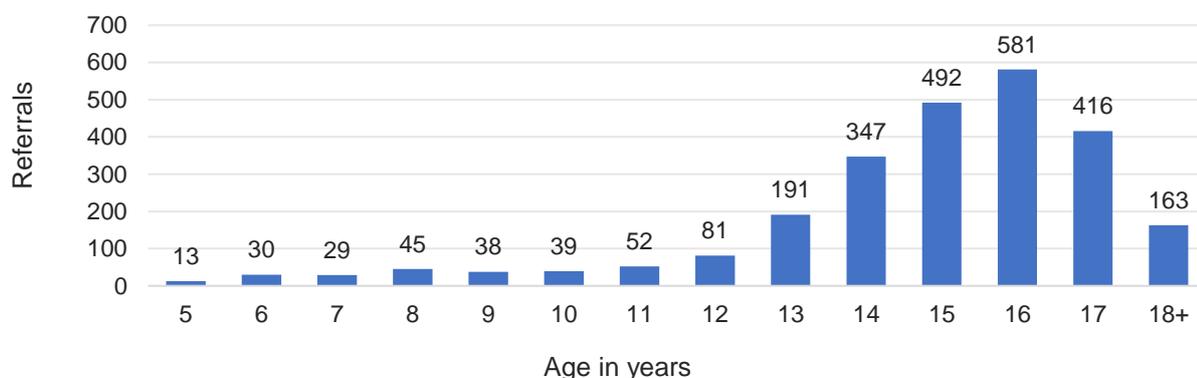
2.3. Demographics: Scotland and England

Practitioners from clinical and voluntary organisations in Scotland have observed an increase in demand for gender services from both younger adults (under 25-year olds) and pre-pubertal children (Thomson et al. 2018: 70).¹⁷

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).¹⁸

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



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).¹⁹

Practitioners in Scotland have also observed an increase in referrals of individuals with complex presentations or autistic-spectrum disorders (Thomson et al. 2018: 71).²⁰ 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),²¹ and a higher risk of autistic-spectrum conditions (GIDS online).²²

¹⁷ See note 16.

¹⁸ See note 16.

¹⁹ See note 16.

²⁰ See note 16.

²¹ Strang, J, et al. (2018) *Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents*. Journal of Clinical Child and Adolescent Psychology 47: 105-115.

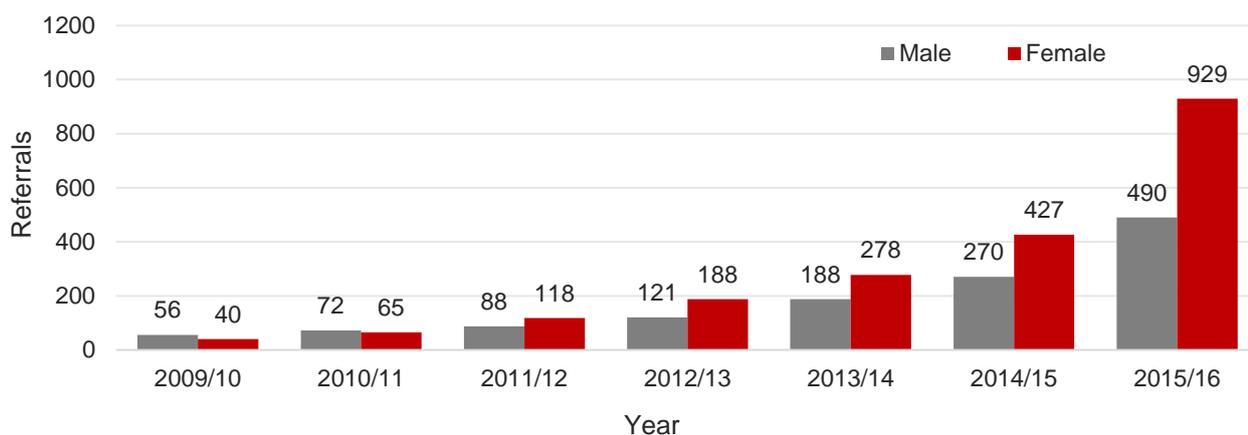
²² Gender Identity Development Service (online) [Evidence base: autistic-spectrum conditions](#).

2.4. 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.²³ In 2017/18, natal girls accounted for 72% of referrals to GIDS.²⁴

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 (under 18s) 2009/10 - 2015/16



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).²⁵

This uneven sex-distribution is evident in Canada, the United States, Finland and the Netherlands (Marchiano, 2017).²⁶ Research from Finland also shows the over-representation of complex adolescent females presenting at gender clinics (Kalatjala-Heino et al., 2015).²⁷

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.²⁸

²³ Telegraph (2018) [Minister orders inquiry into 4,000 per cent rise in children wanting to change sex](#). 16 September 2018.

²⁴ See GIDS: [Gender Identity Development Service statistics](#) (undated); [GIDS referrals increase slows in 2016/17](#) (2017).

²⁵ See note 16.

²⁶ Marchiano, L. (2017) [Outbreak: On Transgender Teens and Psychic Epidemics](#). Psychological Perspectives. *A Quarterly Journal of Jungian Thought*. Volume 60, 2017 - Issue 3: Gender Diversity

²⁷ Kalatjala-Heino, R., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). [Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development](#). *Child and Adolescent Psychiatry and Mental Health*, 9 (9)

²⁸ See note 23.

2.5. Risks and gaps in the medical 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)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)³⁰

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

- 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).³¹

The risk of increased medicalisation is significant because there is currently a lack of professional 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)³² state that the evidence on the medium-term benefits of hormonal treatment and puberty blockers is based on weak follow-up studies (see Biggs, 2019 for evidence on the roll-out of puberty blockers by the Tavistock clinic).³³ The NHS Scotland Gender Reassignment Protocol (2012)³⁴ also acknowledges that ‘there is limited data on

²⁹ Littman, L. (2018) [Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports](#). PLOS One 13 (8). Updated March 2019.

³⁰ Midgen, M. (2018) [Transgender children and young people: born in your own body](#) (Book review). Journal of Child Psychotherapy, 44: 140-142.

³¹ Byng, R., Bewley, S., Clifford, D., and McCartney, M. (2018a) [Cteea/S5/18/Cb/26 Culture, Tourism, Europe and External Affairs Committee Census \(Amendment\) \(Scotland\) Bill](#).

³² Byng, R., Bewley, S., Clifford, D., and McCartney, M. (2018b) [Gender-questioning children deserve better science](#). Lancet, vol. 392: 2345.

³³ Biggs, M. (2019) [Tavistock’s Experimentation with Puberty Blockers: Scrutinizing the Evidence](#). Transgender trend. 5 March 2019.

³⁴ NHS Scotland (2012) [Gender Reassignment Protocol](#).

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. (2018)³⁵ argue puberty blockers are 'being used in the context of profound scientific ignorance', given that the 'causes of [gender-dysphoria] are largely unknown as are the reasons for its rapidly changing epidemiology'

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).³⁶

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'³⁷ (Telegraph, 2019).³⁸

Laidlaw et al. (2018)³⁹ 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),⁴⁰ although it is apparent that many children and young people who present with gender dysphoria do not persist into adulthood (Scottish Government 2018: 133 para. 4.2).⁴¹ Outcomes may however be influenced by medical intervention. For example, Richards et al. (2019)⁴² 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).⁴³

³⁵ Richards, C., Maxwell, J., McCune, N. (2019) [Use of puberty blockers for gender dysphoria: a momentous step in the dark](#). Archives of Disease in Childhood. Published Online First: 17 Jan 2019.

³⁶ Laidlaw, M., Van Meter, Q., Hruz, P, Van Mol, A. and Malone, W. (2018) [Press release for: Letter to the Editor: Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline](#). Journal of Clinical Endocrinology and Metabolism.

³⁷ 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](#)).

³⁸ Telegraph (2019) [NHS staff being advised to ignore parents' wishes if children self-declare as different gender, guidance shows](#). 11 January 2019.

³⁹ See note 36.

⁴⁰ Drucker, J. (2013) [Controversies in Gender Diagnoses](#). LGBT Health vol. 1: 10-14.

⁴¹ 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 15).

⁴² See note 35.

⁴³ Ristori J, Steensma TD. [Gender dysphoria in childhood](#). International Review of Psychiatry, vol. 28:13-20.

Conclusion and suggested next steps

The current gaps in the 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.

Part one suggested that there is a lack of clarity on how the GRA reform proposals would impact on the practical operation of the EqA in relation to the privacy rights of all young people, especially given the variability in its current application.

Part two identified gaps in our understanding of recent trends in relation to transgender and gender-questioning young people and children, including the recent increase in young people seeking support from gender services, and over-representation of natal girls.

There are also gaps in the current medical evidence-base. For example, there is a lack of medical consensus on the medium to longer-term impact of medical intervention (which has implications for fully informed medical consent) and there is a limited understanding of persistence patterns.

These issues need to be considered both in their own right, and in relation to GRA reform given that that some professionals have raised concerns over the risk of increased medicalisation if the proposed changes to the GRA go ahead. Each of these areas should be robustly reviewed and risk-assessed, with input from independent medical practitioners.

Overall, the evidence in this paper suggests that the Scottish Government needs to consider the rights and welfare needs of all children and young people in relation to its GRA proposals. To this end, it is suggested that the Scottish Government undertakes a full Equality Impact Assessment (EQIA) and Child Rights and Wellbeing Impact Assessment (CRWIA) on GRA reform ahead of any legislative steps. 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.