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**Expert Report on
Cornwall Transgender Guidance for Schools**

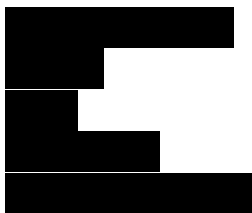
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Introduction

1. My involvement was through recommendation, as a consultant psychologist with a wide range and depth of experience. Qualifying in 1991, then having worked within education, health, and social services in a range of senior roles, it was thought I may be able to take a fresh look at the difficulties presented, in order to address specific questions posed.
2. Central to the concerns of the family who initially presented their difficulties, was a child, a boy aged 6 years, coming to school dressed as a girl. This was causing their child, in the same year group confusion and upset.
3. To add to the confusion, the child sometimes arrived dressed as a boy.
4. However, it was not just one of their children, but also their older child, aged 8 years who had another child presenting in the same way.
5. The family have expressed concern regarding the effects on their own children, other children in the classes and within the school, and the children who were cross dressing (some of the time).
6. The parents raised their concerns with the school, the church authorities, and the education authority.
7. The church authorities responded (14th July 2017) saying that the school did not require any formal medical/psychological assessment and reporting when a pupil seeks to be treated as transgender or is exploring their gender.
8. Further, they stated that the school is legally bound to do as the pupil and parent wish, due to 'Equalities' legislation.

Preparation

9. I have reviewed some of the correspondence written by Mr. and Mrs. Rowe, a response from Mrs. Grainger, head teacher, and the response from the church authorities. I have also reviewed The Cornwall Transgender Guidance for Schools document.
10. I have reviewed numerous documents, including over 300 peer reviewed academic articles, as well as a wide range of other source articles in preparation for this report.
11. I had initially been instructed to comment on specific questions, but in reviewing the questions in light of research, negotiated a change to make them accessible from a research perspective.
12. The following became the focus:
 - To review the existing evidence regarding gender dysphoria with a specific focus on children and adolescents

Using that background information, to comment:

- Developmentally, is there a minimum age, below which a child will be unable to make decisions concerning their gender.
- Can a child's desire to transition to the opposite sex result from factors (psychological or otherwise) other than gender dysphoria?
- Are children damaged by not permitting them to 'transition,' or socially transition, at primary school age, or by not using their preferred non-birth chosen pronoun, names, etc.
- Is there recognised psychological evidence that children expressing a desire to live in the opposite gender, given time, will alter such views?
- What are the dangers with trans-gender affirming policies, in particular the Cornwall Guidance?
- What are the alternative ways to assist with children suffering from gender dysphoria?
- What might the Cornwall guidance have missed?

Executive Summary:

Cornwall Schools Transgender Guidance

13. The 'Cornwall Schools Transgender Guidance' as noted by the local authority was the first of its kind in the UK, constructed with the assistance of outside agencies, council officers and head teachers.
14. At its heart is legislation, The Human Rights Act (**1998**), The Gender Recognition Act (**2004**), and The Equality Act (**2010**), applied to children and adolescents.
15. However, concern was expressed that local authorities were failing to provide protection for children, not only those who may show signs of gender dysphoria, but others within a school setting.
16. The evidence suggests the Cornwall guidance failed to address the obligations of schools and the local authority under Gillick (**1984/85**), and did not take into consideration the position of the CQC or NICE.
17. An emphasis was placed onto on 'equalities legislation,' while research and the needs of young people were ignored. The policy showed little or no appreciation for the safety and welfare of children and adolescent or their developmental needs. The approach of the guidance was 'as if' the children were fully mature adults.
18. The Cornwall Transgender Guidance for Schools appears to be a simplistic response regarding the management of children and adolescents who may potentially form part of the transgender community in the future.
19. The guidance contains no warnings of the effects of transgender medication, many of which were understood at the time the document was produced and additional ones that are now accepted, even by the NHS.
20. The guidance fails to address research, which has shown that, using even the most conservative figure, half (49%) of those initially diagnosed with gender dysphoria, no longer identify as such seven years later. Further, research shows that this number increases as times passes, with one study reporting a figure of 88%: changes that occur during the developmental phase of adolescence.
21. However, the current guidance, shown from two sources relating to the Gender Identity Development Service (GIDS), Tavistock and Portman NHS Trust place this 'change figure,' between 73% and 88%, suggesting that 'on

average,' 4-in-5 children no longer identify with gender dysphoria or the desire to transition as they progress through adolescence.

22. By not informing schools of this rate of change, it inhibits their ability to work constructively with parents and young people.
23. The guidance shows no understanding of the effects of puberty or the process of adolescent development, or its role in this change.
24. The guidance offered to schools appears to miss the role of child and adolescent development, the normal variations in gender and sexual development or the concept of 'safeguarding.'
25. No advice is contained regarding the development of appropriate anti-bullying policies for secondary schools, addressing changes in sexuality and gender identity.
26. It appears that children and adolescents were omitted from the Cornwall Transgender guidance.

Response to specific enquires:

27. Regarding a minimum age below which children could not make decisions regarding gender, it has no simple answer.
28. Gender is in large part shaped by social and cultural norms and child psychologists and others see that younger children will play in a cross-gendered way and to some extent, dress in the same manner for a number of years.
29. Within nurseries, it is common to find children playing in a cross gendered manner, a behaviour that becomes less common as they transition into school.
30. However, gender has a developmental aspect, especially when one reaches puberty, a process that lasts around 4 years, and the start of adolescence, which lasts for 10 to 12 years. Puberty sees the release of multiple hormones, which interact with each other and multiple systems of the body and brain.
31. The decision to transition, at any level, is complex. Changing clothes, names and other features of daily life not only affects the child, but also their relationships with others. Indeed, at school, the notion that one can entirely stop other children being unpleasant in response to differences between them is naive.

32. Whereas one acknowledges that school will try to protect all vulnerable children, in this case, a child with gender dysphoria, bullying and inappropriate behaviour, including social isolation and rejection will happen for many; put simply, 'you cannot force children to play with each other.'
33. The younger the child, the less they will understand these consequences. As children grow, so the issues they need to understand, and address become more complex. Age and the processes of child and adolescent development are critical.
34. A boy aged 6 years attending school in a dress is not necessarily making the decision, as it is the parent who chooses what the child wears and has to purchase the product. Further, as primary aged children frequently have gender neutral uniforms, any emphasis on the child cross-dressing is likely to be influenced, in large part, by the choices of the parent.
35. A child at primary school will not necessarily understand the consequence, in either the short-term or longer term to 'cross dressing.' Such behaviour and its potential for social and emotional harm, to the child, should be registered by the school authorities. The primary school child is highly unlikely to understand the risk to relationships, their social standing in their community, or to their longer-term mental health as a consequence of such cross-gendered behaviour.
36. The issue is not solely about the child per se, but the role of the parent in keeping their child safe.
37. Consenting to 'treatment' means one has to consider Gillick (1984/85). Gillick competence is a functional ability, the more complex the medical procedures, or the 'treatment,' the greater the level of competence required. One need understand not only the advantages and disadvantages with a proposed course of treatment, but the nature and implications that follow from it.
38. Understanding the nature and implications of the treatment of the future requires a higher order of thinking, which does not develop until the time of mid-puberty and through adolescence.
39. Not considering, or addressing *Gillick*, would be a substantial failure by a professional working with young people. Under *Gillick* and the CQC, where a teenager aged 16 or 17 years old acts in a manner to deny treatment that is there to keep them safe, so *Gillick* can be used to intervene, to remove their ability to 'self-harm.' Yet with younger children, not only is *Gillick* available, but

also The Children Act (1989) to protect actions and a lack of actions to protect children and adolescents.

40. Where 16 and 17 year olds are proposing or agreeing a course of action that could potentially cause harm, professionals have a duty of care to ensure the adolescent fully understand the risks.
41. Understanding the complexity of risk, and decision-making regarding such issues has been researched, noting that they are among the final parts of adolescent development, occurring in young males in the early to mid-twenties, and slightly earlier in young women. Mature decision-making regarding risk for complex treatments are beyond most school aged children.
42. There are a variety of conditions that present with similar behaviour to gender dysphoria. Differential diagnosis is essential before proceeding with treatment. A failure to conduct a differential diagnosis may result in inappropriate treatment for the young person.
43. One must appreciate, normal gender variant behaviour is seen in younger children, while non-gender conformity may be both common, and responsible for the 4-in-5 initially diagnosed as having gender dysphoria who 'change their minds;' many of whom will develop over time to be gay, lesbian or bisexual.
44. Based on the research, even the most conservative figure for those diagnosed, who later no longer conform to the diagnosis of gender dysphoria is 49%. That is, from puberty onward, one sees a decline in those who remain gender dysphoric. The GIDS Tavistock and Portman NHS Trust cite an internationally agreed figure for those no longer conforming to the diagnosis and desire to transition, as 73% to 88%, or on average 4-in-5.
45. The rate at which young people no longer wish to transition, and continue down the GD pathway, indicates a developmental aspect to the diagnosis and its treatment.
46. According to research, the rate of abuse suffered by the LGBTQ+ community is very high, with figures around 80% cited. The role of abuse is as yet unclear, but it is associated with the high level of mental illness within this community. The transgender community has very high rates of mental illness.
47. 35% of those referred to the GIDS have moderate to severe traits of autistic spectrum disorder, a disorder of social communication and interpersonal functioning.

48. There appears to be several disorders and issues that 'may' underpin the behaviour of children and adolescents presenting with gender dysphoria. Taking into account the rates of abuse and mental illness, one must assess and treat these elements of the young person prior to treatment for GD.
49. With high rates of young people no longer conforming to the diagnosis, with high rates of abuse, and with high rates of mental illness and high rates of autism one must be very cautious in how one proceeds with treatment.
50. There is no reliable body of evidence to show children are harmed by delaying their transition. Indeed, if offered appropriate support, a delay may enable the 4-in-5 the opportunity to develop in the direction they need; potentially, in their birth sex without the need for medical intervention. Of those who no longer conform to the diagnosis, their sexual orientation covers heterosexuality, homosexuality, bisexuality.
51. Puberty and adolescence are complex developmental stages that progress for over a decade where the release of hormones affects multiple systems of the body including neurocognitive development, as well as social emotional development. IT is a process that ends in the early to mid-twenties.
52. However, potentially, an assessment for gender dysphoria could be completed in just three hours, according to the GIDS.
53. By way of contrast, local authority education assessments may take between two and four years. Psychological assessments for the family courts, by an individual expert witness, may take in excess of 30 hours, while assessment for the criminal courts may take in excess of 20 hours.
54. The comparison in assessment processes suggests concerns over the processes for diagnosing gender dysphoria in children and adolescents.
55. The NHS recognises that treatments with so-called 'puberty blockers' may cause irreversible changes to young people. These changes may occur quickly and form a potential risk.
56. The concept of reversibility is complex and 'developmental.' More complex issues of reversibility require higher order thinking skills, which develop as one progress through adolescence.
57. Cross-sex hormone treatments also contain risk; associated with cardiac events, cancers, and changes in bone density. Research into the risks continues. The medication used is often 'off-label' which carried with it unknown risks. This is acknowledged by the NHS. Surgeries also have a high risk

of short-term complications and risks, some of which require further surgery to correct the difficulties encountered.

58. Social and interpersonal difficulties appear to be common features for many of those who transition. It is probable some will connect to treatment, some to aspects of abuse, some to mental illness and some to autism. Social and interpersonal difficulties may lead to isolation, a sense of rejection, and an increase in risk of self-harming.
59. Controversially, the process of transition does not change a person's biological sex. Indeed, sex differences are present before birth with more than 100 differences in the brain alone. That is, there are 100 differences between a male and female brain. To name but a few others, there are obvious physical differences, men tend to be taller and heavier, men and women process food differently, the structure of the skeleton is different, women lose fertility after 35 years, men can remain fertile into old age, women typically live longer, have less muscle, more fat, and are less prone to autism, ADHD and learning disabilities.
60. One is not reassigning 'gender,' or more specifically sexual identity, but the obvious external signifiers associated with biological sex. Hence, it is the psychological aspects of gender that are at the heart of 'transition,' where medication and surgery being needed in some cases to alleviate extreme distress and discomfort, allowing people to psychologically adjust to the sense of who they think they should be.
61. The development of identity, gender role, and sexuality is an individual experience and all need appropriate support and understanding according to their own needs. These are all areas that develop following the onset of puberty and the movement into adolescence development, a process that takes many years and for the majority is not completed until they are in their third decade of life. Indeed, the World Health Organisation acknowledges and accepts this developmental process (see appendices).
62. Regarding child and adolescent development and gender dysphoria, the biggest risk is from the professionals.
63. An assessment based on as little as three hours, for an area of such complexity is deeply concerning.
64. Assessment errors due to bias, conscious and unconscious, are well-known
65. Errors within hospital medicine occur at a rate of 1-in-10 cases.

66. Errors with psychological/psychiatric diagnosis occur at a rate of 35%.
67. Errors due to poor assessment practice may provide a rate of accuracy and reliability no greater than 50%: a coin toss.
68. The local authority needs to reconsider its approach to the management and support, not of transgender youths, but all young people from the LGBTQ+ community. With around 4% and 6% of the wider community acknowledging themselves within this community, they are likely to form a significant proportion of secondary school children.
69. It is secondary school students who have entered puberty and adolescence who will be in need of this support as issues of gender, sexuality and identity are issues with the adolescent phase of development, which may come together to form a stable sense of self, as one reaches adulthood.
70. Accurate identification and support for those from the LGBTQ+ community should be based around a professional assessment and a professional's judgement.
71. For children and adolescents who may have gender dysphoria, a determination of the condition, better described as non-gender conformity, should be based on a multiagency, multidisciplinary, multimethod assessment conducted over time. The local authority should support such a move, and by doing so, improve the reliability of assessments and their diagnoses.
72. Finally, due to the very high rate of mental illness and abuse suffered by the LGBTQ+ community, social services must be part of this process throughout.

Methodology

73. Research articles were located via PsycNet, NCBI/Pubmed, and Google Scholar. Further articles were located via Google, such as those from the WHO and NICE.
74. Where possible, the aim was to obtain 'neutral articles.' That is, those that drew to the fore the limitations in processes and procedures, in a balanced manner, involved in the areas associated with gender incongruence and gender dysphoria and issues within the LGBTQ+ community; rather than articles that presented an overly biased view, on either side of the debate regarding transgender and transsexuality.
75. I highlight the need to take into account the source material, and the challenge presented, some more balanced in the views offered than others.
76. Further, the ultimate aim was to place this alongside the concept of childhood and adolescence. As such; Gillick, and the concepts of child and adolescent development, and the process of maturation became a focus.

Defining the terms

77. There are a variety of ways in which a 'child's age' and its terminology vary, so I intend to define how two specific terms are being used.
78. The WHO and United Nations (UN) have slightly differing age ranges associated with how they describe young people, but both cease 'youth' and 'young people' aged 24 years. Hence, aged 25 years, the person is 'an adult.'
79. Both WHO and UN can, and do, combine those from 24 years, down to age 14 years, and younger.
80. However, in my case, I will simply refer to the term 'adolescence' as the term from the initiation of puberty and the associated onset of adolescent development, through to the close of adolescence.
81. According to the NHS, on average puberty begins for girls aged 11 years, while for boys, aged 12 years. Hence, I will use 10-to-11 years of age as the start of 'adolescence.'
82. The end of the adolescent developmental period is 21 to 22 years for girls, and 23 to 25 years for boys. Hence, in line with Sawyer et al (2018) in The Lancet, I will use the upper age as 24 years.

83. The terms 'children' and 'childhood,' refer to those up to aged 9 to 10 years.

Children and Adolescents: Gender, an Introduction

84. Sexual orientation and gender roles have for many years, generated much debate between those who state there is only one choice, while for others, there are multiple choices. Hence, the choice is between 'normal' heterosexual relationships between a man and woman and the fulfilment of societies appointed gender roles, and the sexual relations and gender roles other than this. However, history itself has shown that while the majority follow the so-called 'normal,' there has always been a significant minority who do not.
85. Youth and specifically adolescence is a time of change and discovery, a time of maturation and growth. However, the concern is that during this time, or even earlier, decisions on sexuality and gender are made which may have significant consequences. What therefore is the age a young person determines their future relationships and gender roles.
86. Sexuality and gender in the minds of many are two parts of a whole, where gender is the expression of 'sex,' male or female, within one's role within society.
87. The World Health organisation states:
88. "Gender refers to the socially constructed characteristics of women and men – such as norms, roles, and relationships of and between groups of women and men. It varies from society to society and can be changed. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities, and workplaces. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices, or social exclusion – all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.
89. Gender norms, roles, and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental health, physical health and wellbeing. They also have a bearing on people's access to and uptake of health services and on the health outcomes they experience throughout the life-course," WHO, (2019)
90. Hence, gender is "socially constructed," and as such, has the capacity to vary according to the individual's society. Further, it states, "most people are born either male or female," indicting that there is biological variation, some of which will be more obvious at birth, while many others, less so.

91. However, the definition also states, “most people are... taught appropriate norms and behaviours,” and “how they should interact with others of the same or opposite sex.” It therefore suggests that society has a significant role in determining the behaviour of its members, which in turn also indicates the potential risks to some, their manipulation, and exploitation.
92. As noted, the risk for those who do not fit with the social norms included social exclusion, discrimination, and adverse mental health.
93. If one acknowledges that sex and gender are different, it is clear that society has a significant role in determining gender roles and one need consider how age affects the child's ability to take part in this process, for themselves, and the role of maturation. One also needs to consider how young people are supported in their development and decision-making.

Age of consent

94. The notion of 'consent' the ability to make significant decisions about one's life is not fixed and as such, society has built in 'flexibility.' However, for some areas of life, it is the view of society and the culture in which children and adolescents are raised that limits need to be imposed on children.
95. Examples of such societal and cultural controls are such topics as driving, consumption of alcohol, age when people can vote etc. More widely, different cultures and societies impose rules on sexual behaviour, with a view that young people need time to mature, in order to make appropriate decisions regarding relationships.
96. The age of sexual consent is similar across most of Europe (14 to 18 years). Worldwide, the age range varies, but broadly 14 to 21 years. For the UK, sex with anyone 15 years and younger is a crime; the child cannot give consent. Hence, the choice that children have, and when and how this is provided to them, depends upon age, society, culture and the topic under due consideration.
97. For children in the United Kingdom the guiding principle is that of the '**Gillick Competency**' and the '**Fraser Guidelines**' the outcome following the 1985 judgement by the House of Lords which looked at the ability of professionals to give contraceptive advice and/or treatment to those under 16 years without parental consent.
98. Stilled quoted in NICE June **2019** the process of consent is as follows [Gillick v West Norfolk, **1984**]: “...whether or not a child is capable of giving the

necessary consent **will depend on the child's maturity and understanding and the nature of the consent required.** The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent" [Emphasis added].

99. Fundamental is the balance between the need to listen to the child with the responsibility to keep them safe. NSPCC from June **2019** notes, as found on the NICE website...
100. Lord Scarman's comments in his judgment of the Gillick case in the House of Lords (*Gillick v West Norfolk*, **1985**) often referred to as the test of "Gillick competency". He said: "...it is not enough that she should understand the nature of the advice which is being given: **she must also have a sufficient maturity to understand what is involved.**" [Emphasis added].
101. He also commented more generally on parents' versus children's rights: "Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."
102. Professor Nigel Sparrow senior national advisor and responsible officer at the Care Quality Commission (CQC): One immediately notes, Fraser and Gillick refer to two separate processes, the advice for contraception (Fraser), and the ability to consent to medical treatment when under 16 years of age (Gillick).
103. The Gillick test refers to: "They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions."
104. To balance this, Professor Sparrow, writing in the 'CQC essential' (**2018**) describes the following: "In law, a person's 18th birthday draws the line between childhood and adulthood (Children Act **1989** s105) - so in health care matters, an 18 year old enjoys as much autonomy as any other adult. To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents. The right of younger children to provide independent consent is proportionate to their competence - **a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.**" [Emphasis added]

"16-17 year olds

105. Young people aged 16 or 17 are presumed in law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their

refusal of treatment can in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

Under 13

106. There is no lower age limit for Gillick competence or Fraser guidelines to be applied. That said, it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent's involvement. When it comes to sexual health, those under 13 are not legally able to consent to any sexual activity, and therefore any information that such a person was sexually active would need to be acted on, regardless of the results of the Gillick test."
107. However, connecting this to the above, 16 and 17 year olds cannot drive cars, buy alcohol, get married etc. Society has clearly decided that certain actions and decisions are beyond the capacity of children. Therefore, one might reasonably suggest that the taking of hormone-blocking medication to prevent the onset of puberty, something of which they have no experience and limited understanding, is a decision that requires extreme caution.

The Gillick competent child under '18 years'

108. Based on Sparrow (2018) one can reasonably argue that young person's 16 and 17 years old are able to consent to treatment as if they were of 'full age.' However, their Lordships, from *Gillick (1986)* were clear, the young person "had the legal competence to consent to medical examination and treatment **if they had sufficient maturity and intelligence to understand the nature and implications of that treatment,**" [Emphasis added].
109. The issue is not one of age alone, as noted above, but maturity, intelligence and understanding. Further, one need understand the nature of the treatment, and its implications. Indeed, one particularly notes that the emphasis is on 16 and 17 year olds, and not those who are younger,
110. Griffith (2016) notes that competence addresses the child's experiences, the ability to manage decision-making taking into account the information presented, peer pressures, family pressures and their own misgivings. The question is whether the child can genuinely understand and weigh the risks and the benefits, consider long-term factors and, one would argue, in the case of gender reassignment, the effects on family life, relationships and such things as schooling, higher education and work.

111. They continue; "Decision making competence does not simply arrive with puberty; it depends on the maturity and intelligence of the child and the seriousness of the treatment decision to be made."
112. "Gillick competence is a functional ability to make a decision. It is task specific so more complex procedures require greater levels of competence. It is a high test of competence that is more difficult to satisfy the more complex the treatment and its outcomes become. To date no court has found a child in need of life sustaining treatment competent to refuse that treatment."
113. Regarding gender reassignment, simplistically, the task for youth is to understand the physical, intellectual, and emotional aspects of the change processes, and to understand the risks. They need the capacity/competence to make an appropriate decision. 'Competence' in this case is a high bar, and therefore difficult to achieve.
114. What is required from the professionals is the ability to assess the developmental competence of the child/youth to determine if they are able to make such a decision, a process that has substantial developmental aspects. One is not simply asking if the youth has GD, but more importantly, if they have the capacity and competence to make the decision to transition.

Mini-Summary

115. For any individual, the assignment of gender role and sexual behaviour is a features of the society and culture in which they live their lives. However, where one challenges those norms, for whatever reason, the result may be negative and severe.
116. Societies have rules that restrict the behaviour of children and adolescents, as a means of protecting them, and others. Hence, the age of consent for sexual behaviour is restricted; the age when one can drive a car; the age when one can buy and drink alcohol; get a tattoo; etc.
117. Regarding allowing young people to consent to medical treatment, the two guiding principles are **The Fraser Guidelines**, and **Gullick Competency**; both of which signal when and what type of consent can be given.
118. Professor Sparrow is clear, "a child's age alone is clearly an unreliable predictor of his or her competence to make decisions." Further, "In law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105) - so in health care matters, an 18 year old enjoys as much autonomy as any other adult."

119. Hence, finishing statutory schooling aged 16 years following GCSE's is not enough, according to Professor Sparrow of the CQC, to determine all aspects of 'consent.'
120. It is noted how for 16 and 17-year olds the autonomy to consent can be withdrawn where the decision making of the young person would lead to permanent injury or death. In such circumstances, it tends toward indicating that parental involvement, even if not complete control, would be recommended where such individuals were seeking a course of treatment that could be harmful.
121. One then needs to ask would, or could, the gender reassignment 'process,' be harmful and potentially self-destructive.
122. Whereas the issues of the CQC focus on a refusal to accept treatment and the negative consequences that might ensue, the alternative question needs to be posed; if acting in a way that may cause irreversible physical, emotional, and psychological damage were not an equally appropriate reason for intervening.
123. This is important when one considers good practice regarding medical treatment, where the involvement of parents and youth working together should produce better outcomes for the families and the individuals involved.
124. However, competence to decide needs to address the ability to understand what one is consenting to, taking into account the procedures, long-term consequences and implications across multiple areas of life. The more complex the treatment and its effects, the higher the degree of competence required.

What is involved in gender reassignment?

125. A brief, independent, review of gender reassignment makes it is clear that there are a number of limitations with the process, and secondly, researchers and society lacks knowledge of the long-term effects.
126. What follows is primarily derived from two databases, PsycNET and NCBI/Pubmed.
127. One notes that gender reassignment or 'Gender Affirming Surgery' (GAS) is used to treat gender incongruence/dysphoria for which the effects of success are 'mixed,' both in terms of the procedures and psychologically.
128. Whereas on the one hand, the process of surgery, over the medium to long term may be successful, the success concerning the alleviation of mental health symptoms is more varied.
129. The process of surgical treatment has a specific focus on external genitalia and not on gender per se, nor on the underlying psychological state and the patient's mental health. The ongoing presence of mental illness is noteworthy. Gender dysphoria is not simply believing that one is in the 'wrong gender body,' but has significant mental health issues for many, issues of gender role, and issues related to 'self.'
130. An 'acceptance' that surgery addresses external genitalia is shown by modern research and modern papers, showing that gender differences are found in foetal growth and foetal brains, Lampl et al (2010); Wheelock et al (2019).
131. Indeed, even the laying down of grey and white matter in the brain shows gender differences; male brains utilising seven times more grey matter (information and action processing) than females, while females brains utilise nearly ten times more white matter (a networking grid, connecting grey matter). This difference may explain why men are task focused and can struggle to change once focused, while women are far more mentally flexible.
132. There is also evidence that there are structural differences, with the development of female brains showing verbal centres in both hemispheres, while male brains tend toward the left. Additionally, it has been suggested that female brains have a larger hippocampus with a higher density of neural connection leading to it. The hippocampus is connected to memory centres and the absorption of a wider range of 'sensorial' information.

133. "Scientists have discovered approximately 100 gender differences in the brain, and the importance of these differences cannot be overstated," Jantz (2014).
134. Regarding surgery, for a man the penis is essentially 'removed' while preserving blood and nerve supplies so that the body of the penis can be formed into a working vagina.
135. However, this is an artificial creation, and as such, to enable the vagina to operate in a similar way to a 'natural vagina,' the individual needs to use lubricants and dilators. These enable the vagina to maintain an appropriate size for, and ability to accept a penis, for intercourse. The surgical process called 'vaginoplasty,' is often accompanied by 'labiaplasty,' the construction of the external labia.
136. However, as with all surgeries, there are risks; Gaither et al (2017) show 28.7% of patients experienced postoperative complications; Massie et al (2018) reported 26% of patients experienced granulation, 20% experienced intravaginal scarring, while 20% experienced prolonged pain. Ives et al (2019) reported 16.8% of patients experienced major complications, while 35.6% experienced minor complications. Levy et al (2019) reported a reoperation/revision rate of 7.9%.
137. That is, the 'Gender Affirming Surgery' has immediate short-term issues that need to be understood by the patient, and requires a life-long commitment to the maintenance of the new biological structures; the surgical process itself is not without some risk (see later).
138. This immediately begs the question, when is the patient told of such issues?
139. In understanding gender reassignment one need understand the commitment required. The new vagina does not have the usual self-cleaning and self-lubricating facilities. It does not have the same ability to adapt over time. Further, the lubricants and dilators are used to keep the vaginal space open; otherwise, it will/may close, potentially requiring further surgery.
140. Hence, if a younger person were to undergo surgery, they would need evaluating regarding their ability to remain committed to such processes. Repeatedly saying you have commitment is not the same as demonstrating commitment, especially when that commitment to action is put to the test.
141. What is the evidence the professionals are using to determine such commitment?

142. Developmentally, young people are more impulsive than those who are older, due to maturational processes; one specifically refers to the role of the pre-frontal cortex and its role in impulsivity and risk taking behaviour where this part of the brain does not fully mature until the late teens through to early mid-twenties. It is an area of the brain intimately connected to decision-making.
143. How do surgeons assess this developmental stage and potential impulsivity, to ensure patients are protected from themselves?
144. Hormones address the development of breasts, or alternatively, surgery addresses the removal of such in women. Hormone treatment is typically the first part of treatment for gender dysphoria.
145. Research indicates that use of the medication is typically, what is called, 'off label.' Hence, the longer-term effects may be less clear, including dosage required and the management of side-effects. These limitations are likely to be of greater risk for those who are not yet fully mature: children and adolescents.
146. For women, the blood supply and nerves of the vagina and external structures are preserved, while creating an artificial penis, often using the clitoris and/or skin grafts, which together with the mastectomy is part of female to male, gender affirming surgery. However, as the tissue required for an erection does not exist, there are additional procedures that may be required for engagement in penetrative sex. The urethra also needs extending to enable urination. These additional procedures to enable intercourse can be successful, but not all GAS's enable such interpersonal interactions.
147. However, in ensuring that young people are made aware of their commitment, it is the focus on genitalia, and not gender, which causes concern. Whereas genitalia are the outward expression of gender, gender is more than whether an individual has a penis or vagina.
148. As there are nearly **600 biological differences** between men and women, more than 100 in the brain alone, one need acknowledge that all that is being 'resolved' are a few external issues. The Adam's apple may need treatment; as may the vocal chords, the jaw line may need treatment; the brow ridge may need treatment. The development of broad male shoulders may be beyond treatment, as are inherent height differences between men and women. The position of the hips and therefore the way men and women walk, among other features, cannot be resolved; nor can the differences within the brain itself.

149. Hence, there is a focus on genitalia, and a few 'facial features,' but many of the other differences are beyond treatment. One might reasonably argue that the need for treatment also includes the need to understand the patients view of what being reassigned will mean, how and why their life will be 'different,' and how they expect to look following surgery.
150. Further, with interventions leading to gender reassignment beginning earlier in a young person's life one need ask, does a pre-pubescent child understand puberty and the changes in self-identity and the concept of sexuality?
151. Further, what is the pre-pubescent child's experience of gender roles, as an adult? Whereas the answer may be obvious, gender roles change as one progress through adolescence, as they do across social roles. Further, as the generation's progress, so gender roles change.
152. Increasingly hormone-blocking is being used with pre-adolescents, however this does not alter the fact that there are nearly 600 differences between men and women, a process of differentiation that begins well before birth.
153. Of course, one has to ask, where is the evidence to suggest that the use of hormone blocking medication is safe to use with pre-adolescents?

Mini-Summary

154. For young people diagnosed with gender dysphoria, they need to understand what 'transition,' might entail and the limitations of it. It is not risk free and the medications that are being used are not approved for the use prescribed; known as 'off-label.'
155. As with all operations, there are inherent risks and in the case of GAS, several operations are required, to alter the face and throat, as well as a separate series of operations to alter the appearance of the genitals.
156. However, transition does not stop when the final operation has been completed but is ongoing with the need for life long off-label medication and the maintenance of the new body parts.
157. 'Transition' does not alter 'gender,' but alters some of the external signs of such.
158. The issue for a young person becomes their ability to 'fully understand' the procedures, their ability to consent in terms of Gillick, and to do so at an age consistent with The Children Act (1989).

Off-label medication

159. When 'not-off label,' - "A licensed medicine meets acceptable standards of efficacy, safety, and quality.
160. A marketing authorisation or product licence defines a medicine's terms of use. It addresses its summary of product characteristics outlining, among other things, recommended dose(s), contraindications, and special warnings and precautions for use on which the licence is based. Further, in line with such use, the benefits of the medicine were judged to outweigh the potential risks.
161. A licensed medicine: has been assessed for efficacy, safety, and quality; has been manufactured to appropriate quality standards; and when placed on the market is accompanied by appropriate product information and labelling."
162. Hull University Teaching Hospital - "What is 'Off-Label' use of medication? Explains as follows; Off-label' use means that the medicine has a license for treating some conditions, but that the manufacturer of the medicine has not applied for a license for it to be used to treat your condition. In other words, the medicine may not have undergone clinical trials to see if it is effective and safe in treating your condition."
163. "Conclusions - The level of evidence published on the harm from off label and unlicensed medicines use in children is scarce. There is however sufficient evidence that harm actually occurs and is underreported. This supports measures to improve information on medicines used in children. This also supports setting up prospective monitoring of ADR's in children, including for children in the community, in order to obtain an objective picture of the risks and benefits of paediatric medicines."
164. In short, the medical profession is aware there are risks with the use of off-label medication, especially in younger patients, and that for some the use of such medication is harmful.
165. Maravelis et al (**2005**) reported the use of anabolic steroids with Eastern European athletes, children and adolescents, finding long term consequences. Adverse effects include, "serious and irreversible organ damage," "hypertension and atherosclerosis, blood clotting, jaundice, hepatic neoplasms and carcinoma, tendon damage, psychiatric and behavioural disorders", p 167.
166. Singh-Ospine et al (**2017**) showed the use of sex hormones was associated with a change in bone mineral density, potentially increasing fracture risk.

167. Tangpricha and Heijer (2017) considering oestrogen and anti-androgen therapy saw the risks of treatment as low, but acknowledged, “thromboembolism, the risk of which depends on the dose and route of oestrogen administration. Other associated conditions commonly seen in transgender women include increased risks of depression and osteoporosis.
168. Thromboembolism: simplistically, a blood clot that blocks a blood vessel; which may cause heart attacks and/or strokes. Osteoporosis: where bones weaken and may become fragile and break.

Risks

169. Applying *Gillick*, it is not enough to understand the basic procedures involved in GAS, but one also need understand the risks and long-term implications of treatment.
170. For both men and women there are numerous issues to consider. However, most reports focus on surgical procedures and their success, not necessarily addressing the underlying issues that required such treatment, the gender dysphoria.
171. Gender dysphoria according to the NHS is not a mental illness, whereas in the USA ‘gender non-conformity’ is not a mental illness, but gender dysphoria can be.
172. The critical difference is that gender dysphoria has/or can cause clinically significant distress and dysfunction in daily life, while gender non-conformity does not. This is important because the former represents a ‘disorder,’ while the latter does not.
173. Added into the equation are the very high rates of mental illness and attempted suicide within the LGBTQ+ communities. Whereas the causes are open to debate, the presence of such, especially in the transgender community, is established in the research.
174. Gender dysphoria is not a sexual disorder but separate from such. Gender dysphoria in children was acknowledged in DSM-5 (APA, 2013); see appendices. ICD-11 (WHO, 2018) recognises ‘gender incongruence’ and ‘gender incongruence of childhood,’ the equivalents of Gender Dysphoria/DSM-5; see appendices.
175. The conditions are characterized by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which

may begin before puberty. According to ICD-11, "the diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

176. The advice offered to families and individuals regarding treatment, and the successes claimed, often needs to be treated with care:
177. As with many elective surgeries, satisfaction was reported to be very high, Van de Griff et al (**2018**) noted only 6% 'dissatisfaction.' This was linked to psychological factors, indicating the pre-operative involvement of therapy would be useful.
178. However, the study approached 546 eligible individuals, of whom only 201 responded. Therefore, 94% of 201 (94% = 189 people) expressed 'satisfaction.' 189 people is equivalent to 35% of the original group. It is therefore possible that 35% were satisfied, but 65% were not; we simply do not know. This 'statistical shortfall,' starting with 546 people and reporting on just 201 is common, and potentially very misleading.
179. Additionally, Mostrey et al (**2011**) note numerous post-operative risks and post-operative complications involved in more than 40% of cases, related to the development of the urethra alone, though other reports suggest 80% complications with remaining concern over the long term effects on 'the bladder' being unknown and in need of further research. Indeed, even without 'complications,' breast reconstruction requires 25% follow up surgery for aesthetic reasons. It was reported that up to 80% of those receiving erection prosthesis were successful regarding the ability to engage in sexual intercourse; though again with caution, if 80% are successful, it appears 20% were not?
180. A study by Dhejne et al (**2011**) involving 324 gender reassigned individuals showed as follows: "Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group."
181. More specifically, "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population."
182. The point being, for some, gender reassignment carries a significant risk of death following surgery. The psychological issues involved within the individual prior to reassignment are not removed. Indeed, the risks for further psychiatric care were also greater than their age and gender matched population.

183. Other indicators of social discordance were high: Substance misuse was three times as great for the post-operative group compared to controls, Psychiatric hospitalisation was over four times for the transgender post-operative group and 'attempted suicide' was eight times as great for the transgender post-operative group.
184. This is the so-called 'Cohort study in Sweden,' used as the current standard for long-term evaluation of the post-operative transgender community.
185. However, the latest study involving 2,679 individuals with gender incongruence (transgender or gender identity disorder), mental health treatment was examined as a function of length of time since gender-affirming hormone and surgical treatment. Outcome measures were anxiety disorder, health care visits, antidepressant, prescriptions, and hospitalisation after a suicide attempt.
186. They found that hormone treatment did not affect mental health, but years since gender affirming surgery did improve mental health. However, further work is required to better understand the current findings, Branstrom and Pachankis (2019).
187. One is cautious as it is established that time and age affects long-term mental illness, irrespective of 'the cause.' That is, as people age, so mental illness generally improves.
188. Interestingly, Cornell (University) undertook a review, "What does the scholarly research say about the effect of gender transition on transgender well-being?"¹
189. They note transition can be effective in treating gender dysphoria, and over the long-term can lead to better mental health and better and more stable relationships.
190. However, normal aging process also leads to the same outcome, and the online analysis did not say whether this had been considered within their assessment. That is, anxiety and depression both improve as patient's age, even without treatment.
191. Further, the Cornell analysis has a contradiction. Access to treatment and social support was important and without it, mental health difficulties

¹ <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>

persisted. That is, are the long-term improvements noted by Branstrom and Pachankis, due to post-operative treatment availability, and the availability of social support? In essence, Cornell raise the possibility that the underlying issue for many may be one of mental illness, as opposed to issues of gender per se?

192. Nevertheless, Cornell note that transgender research is still difficult to conduct and limited in its range and depth. They state, "Transgender outcomes research is still evolving."

Note: Off-label

193. Karin Svens, PhD, ERT (European registered toxicologist); consultant, chemical risk assessment and drug development and Sven Román, child and adolescent psychiatrist; psychiatrist consultant, own company, Stockholm (2019) Title: "Off-label prescribing of hormones in gender dysphoria should be investigated" commented as follows on off-label medication:
194. "Recently, the Anova Clinic in Stockholm held its regular information day on gender dysphoria. One clear message from this meeting was that it is essentially risk-free for girls to take testosterone (and estrogen for boys) from their teens and throughout adult life. If the clinic provides the same information to patients, they are communicating serious and potentially damaging misinformation."
195. "Data from sportswomen from Eastern Europe who were exposed to various anabolic steroids (including testosterone) for a time in adolescence show a range of side effects in addition to masculinizing effects: including polycystic ovarian syndrome, severe liver injury, and delayed growth (in teens)."
196. "An increased incidence of myocardial infarction and possibly stroke was seen in transmitters treated with testosterone after a follow-up period of just over four years. After 12 weeks of use, testosterone induces mitochondrial dysfunction in transmitters."
197. "In April 2019, the Swedish Medical and Ethical Council (Smer) proposed that the Ministry of Social Affairs should commission three authorities to review gender dysphoria and the treatment of children and young people. The Agency's task – to examine off-label prescribing of sex-controlled hormones – has not been initiated. Given the obvious risks, one might wonder why?"
198. "Treatment with sex-controlled hormones in young patients (under 25 years) should be discontinued and the risks investigated. Only if and when the benefit is deemed to exceed the risks should it be resumed."

199. One of the authors, Karin Svens is the parent of an adult transsexual who is satisfied with her transition.
200. Further, one notes increased concern being raised regarding the treatment of children and adolescents self-identifying as transgender: "The troubles around the Gender Identity Development Service's study seem to be symptomatic of our wider collective failure to determine whether, and when, we should prescribe puberty blockers, or cross sex hormones, to children and young people identifying as transgender. The ethics of research conduct belongs to the Health Research Authority (HRA), and the quality of science is an important consideration when determining ethics. Some procedural issues might not be serious, but the HRA did not try to determine..."
201. Conversely, Byng and Bewley (2019) argue the contrary in their article Gender dysphoria: scientific oversight falling between responsible institutions should worry us all.
202. More specifically in an article by Bewley et al (2019) referencing UK practice:
203. "More individuals are requesting medical assistance for gender uncertainty or dysphoria and provision of adult NHS gender identity services (GIS) is changing. Despite minimal medical input to polarised debates, several issues are potentially concerning: **reports of poor care**; rapid rises in referrals of children and young people to GIS; public conflation of biological sex with socially influenced gender roles; and **extensive uncertainty in the evidence base to guide practice**.
204. Medical practice should happen within robust human rights frameworks where individual patients always have their concerns heard. Generalists, with expertise in whole-person care, handling uncertainty and complexity, have a key role when consulted by identity-questioning and transgender individuals for routine care, gender identity concerns, treatments recommended by private or NHS services, or for referral. Presentations with prior emotional trauma, co-existing mental or neurodevelopmental issues, or 'bridging hormones' requests may make primary care professionals uneasy. Without a considered approach to practice, high-quality evidence and guidance, a policy of active 'affirmation' and 'treat or refer' may lead to more people receiving medical interventions with **uncertain outcomes**," p 170. [Emphasis added].
205. Much of this applies to children and adolescents.

Mini-Summary

206. According to The World Health Organisation, ICD-11 (2018) "The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis," This therefore limits how primary school aged children can and should be managed in regard to 'non-gender conformity.'
207. There is a high rate of complications with surgery, with corrective procedures needed. Over the short-term, mental health difficulties appear to persist within the transgender community following surgery. On the surface, this contrasts with longer-term improvements in mental health and life satisfaction, though the reasons for these are as yet, unclear.
208. Important factors for long-term improvements in mental health are access to good mental health support before and after surgery, along with strong social support systems.
209. Serious concerns are being expressed regarding the use of off-label medication, especially with children and adolescents, with a recommendation by some experts that all such treatment should cease until a full review of benefits and risks has been undertaken.
210. The long-term risks with the use of off-label medication include cancers and cardiovascular incidents.
211. As of 2019, no such review of safety had been undertaken. One might suggest that even when reaching adulthood, aged 18 years, the dangers with medication are significant. It is a concern that if this were any other medical setting, i.e. not a GD issue, the potential risks would have a higher status and as a result would affect treatment.

The NHS Perspective, in brief

212. What follows is essentially a cut-and-paste from the NHS, downloaded July 2020, and is therefore up to date and relevant².
213. “Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.”
214. This indicates that the NHS is prepared to engage, with children and young people in the use of treatments where the risks are ‘unknown.’ Whereas this is not unusual, it does suggest that past NHS errors have not been considered.
215. Within normal practice, the NHS 2nd May 2012 reported:
“In all, 1 in 20 prescriptions written featured an error. Of the errors, 42% were judged to be minor, 54% moderate, and 4% severe”³³.
216. Hence, for children and adolescents, the risks of the medication are not fully understood, and then there is 1-in-20 change of human error, just in prescribing.
217. Further, it raises the issue of the Care Act, (2014), which begins:
“The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual’s well-being.”
218. It continues:
“Well-being, in relation to an individual, means that individual’s well-being so far as relating to any of the following—
(a) personal dignity (including treatment of the individual with respect);
(b) physical and mental health and emotional well-being;
(c) protection from abuse and neglect;
(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)”
219. In such circumstances, one might wish to consider the role of the local authority in protecting its children from potentially dangerous medical treatments, where the outcomes of treatment are unknown, especially in light of the requirements of the Care Act 2014⁴. The NHS again states:

² <https://www.nhs.uk/conditions/gender-dysphoria/treatment/>

³ <https://www.nhs.uk/news/medication/prescriptions-1-in-20-has-an-error/>

⁴ <https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/general-responsibilities-of-local-authorities/enacted>

220. "Although the Gender Identity Development Service (GIDS) advises this is a physically reversible treatment if stopped, it is not known what the psychological effects may be."
221. They 'advise' or they know, based on long-term research?
222. There is evidence to suggest this statement may be out of date. It is known that drug treatments may have lasting effects. Hence, even before surgery it appears to be possible to permanently damage children.
223. However, there is acknowledgement by the NHS that stopping treatment once started may have unknown consequences for/on the young person.
224. "It's also not known whether hormone blockers affect the development of the teenage brain or children's bones. Side effects may also include hot flushes, fatigue and mood alterations."
225. As one will see later in this paper, adolescent development is extremely complex and interfering with one element through the use of puberty blockers, with the view that other areas of development would not be affected is improbable.
226. The World Health Organisation (2020) clearly shows how adolescent development is complex, multifaceted with multiple systems being inter-related (see appendices).
227. The NHS position appears to be to state they do not know what will happen, then minimise the effects to 'hot flushes, fatigue an mood alterations' which as any parent of an adolescent will appreciate, is the description of many/most normal adolescents.
228. "From the age of 16, teenagers who've been on hormone blockers for at least 12 months may be given cross-sex hormones, also known as gender-affirming hormones."
229. This suggests that hormone blockers are used with children/adolescents under 16 years old.
230. "Who've been on" suggests medication began before 16 years, which appears to fall outside of guidance. It suggests clinics may be ignoring *Gillick*?
231. "These hormones cause some irreversible changes, such as:
- breast development (caused by taking oestrogen)

- breaking or deepening of the voice (caused by taking testosterone)
 - Long-term cross-sex hormone treatment may cause temporary or even permanent infertility.”
232. This appears to be a contradiction to: “Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.”
233. However, already known are the long-term effects of oestrogen including, blood clots, heart disease, and strokes. These are known risk with the use of HRT, as found on the NHS website, and other sites associated with GD.
234. The long-term effects of testosterone therapy include cardiovascular problems, including heart attacks, strokes, and death⁵⁵.
235. “There is some uncertainty about the risks of long-term cross-sex hormone treatment.”
236. Again, the NHS is aware of uncertainty in the treatment of GD, yet appears to want to allow those who are not yet adults (Children Act, 1989) to access uncertain and potentially dangerous treatments.

LGBTQ+ community: Risks

237. Note: most research has focused on LGB groups and more recently on LBGT, with Q, being a newer group, and + again, representing newer groups (IA)
238. WHO recognise that ‘attempted suicide’ occurred at a rate 20 times that of those who ‘completed the suicidal act.’ Hence, attempted suicide occurs at a much higher rate than ‘suicide’ per se.
239. However, more specifically, for the LGBT community attempted suicide rates vary between 20% and 53%, McDaniel et al (**2001**), Scanlon et al (**2010**) and Grant et al (**2011**). Hence, within the community itself, rates of ‘attempted suicide’ appear to be very high, though deaths resulting from it may be much lower.
240. Technically, the WHO and research data are not directly comparable, one noting ‘rates,’ the other, ‘percentages.’ However, together, they indicate that attempted suicide is found more frequently than ‘completed,’ that results in death.

⁵ www.health.harvard.edu/mens-health/is-testosterone-therapy

241. Nevertheless, for the LGBTQ community these figures indicate the need for access to mental health services and raise doubt about the view of the NHS who notes that gender dysphoria, and gender/sexual orientation related issues are not a mental illness. Whereas this might be true, mental illness is associated with many conditions within the LGBTQ community; though one is not surprised given the high rates of abuse suffered within childhood by this community.
242. More generally, in the UK, there were 6,507 suicides in 2018. Suicide rates are three times higher for men than women, ONS (2019). Death rates increased from the previous year by 23% in the under 25's. In Scotland, since 2007 there has been a 52% increase.
243. Stonewall (2019) note; "More than one in four (27 per cent) trans young people have attempted to commit suicide and nine in ten (89 per cent) have thought about it. 72 per cent have self-harmed at least once. (from, Youth Chances 2014, sample size = 956)"
244. Further, "Almost half (48 per cent) of trans people in Britain have attempted suicide at least once; 84 per cent have thought about it. More than half (55 per cent) have been diagnosed with depression at some point. (from, Trans Mental Health Survey 2012, sample size = 889)"
245. Armstrong (2019) using data from The Mental Health Foundation noted that 1-in-8 adults have suicidal thoughts, with 33% of the lesbian, gay, and bisexual community having suicidal thoughts related to body image, compared to 15% of women and 11% of men.
246. As Armstrong is referring to research undertaken by YouGov in March 2019 with 4505 UK adults, it is up to date and uses a large sample size.
247. However, one also notes that opportunities for prevention may exist, because research suggests there are differences between suicide attempters and suicide completers, as they use different methods, one being significantly less lethal than the other, Lee et al (2014).
248. However, as Moody et al (2015) note, the rate of completed suicide is unclear in the trans/GD community, due to the lack of studies at this time. Further, they suggest that the data has an inherent bias due to the groups collecting it.
249. Moody et al (2015) looked at suicide prevention and the factors involved and hence, prior to any decision to proceed with gender reassignment procedures, one might argue that both the individual and the family need to

explore issues of gender reassignment, and the issues of self-harm and improving mental health.

250. These issues are often age-related, where self-identity is often unclear until a person has passed through adolescence and the effects that normal ageing processes have on the body and brain development.
251. Rates of self-harm and suicide can be reduced, Bauer et al (2013), McNeil et al (2012), though this involves working through the process of 'prevention.' That is, there is a need to evaluate the underlying processes behind self-harming in order to protect the GD individual prior to surgery.
252. However, according to WHO, suicide in the age range 15 to 29 years, is the second highest cause of death worldwide. In the teenage years, the worldwide rates are similar for male and females, while progression into the 20's sees Males overtaking females (2016 data).
253. The WHO data is useful because it provides 'crude data' against which to compare any other group. In essence, it forms a baseline against which others are compared; are they greater or lower than the WHO total estimate.
254. Regarding young people of school-age, Vander Stoep et al (2009) looked at 4447 public school students, finding over a three year period; 70% did not report any suicidal thoughts. However, this left the remaining 30%, with 6% of the total reporting high suicidal ideation scores.
255. This study provides a simple baseline against which other rates of suicidal thoughts and ideation (**sti**) can be compared for those in early adolescence.
256. Indeed, in looking at the data above, it suggests that rates of **sti** grow as one matures into mid to late adolescence, declining as one reaches adulthood.
257. The difference between the mainstream and those from the trans' community appears to be significant.

Bullying

258. Bullying is a common problem found in all schools and recognised as a feature within most.
259. It is often associated with 'difference,' where a child differs from others due to some specific or general feature, for example, wearing glasses, colour of their skin and so on. Such difference can lead to a wide range of victimisation, including physical aggression, verbal aggression, rejection and social

isolation.

260. In theory, schools address bullying with whole school policies and their implementation into practice. However, the effectiveness of such approaches is often poor.
261. The reasons for this vary, such as some children will respond to the policy while others do not. Hence, some will continue to bully, while others will continue to be victims, Nocentini et al (**2018**). That is, the policy and its practice have no effect of some children.
262. For others, it is the role of the teacher, their attitude toward the policy, or the child, the issue generating the child's victimisation, the view of the teacher that they have the skill to cope and manage bullying and so on, Verseveld et al (**2019**).
263. Bully and victim present with a wide range of behaviours, some of which appear to have a genetic component, while others are environmental. Hence, interventions also need to target both bully and victim, addressing both environmental issues and issues within the individual, Johansson et al (**2020**).
264. One must also appreciate that engagement with the policies and practices is important. Cunningham et al (**2016**) highlighted numerous criticisms from students that significantly undermined the efforts of the schools, boring and poorly developed programs, negatively worded, lacking credibility and so on.
265. Interesting, Kull et al (**2016**) looked at policies aimed at supporting the LGBT community, where students reported less victimisation, less social aggression and higher levels of safety. This result contrasted with school districts that did not implement antibullying policies based on students sexual orientation, gender identity and/or gender expression (SOGIE).
266. The abstract to their article concluded with, "Findings suggest that antibullying policies explicitly enumerating SOGIE protections can improve LGBT school experiences and that generic policies may not sufficiently protect LGBT students from bullying and harassment," p 407.
267. Interestingly, most bullying research focuses on the age group Year 6 through to Year 10, which developmentally, equates to the time of puberty.
268. Further, no research reported the elimination of bullying. Indeed, the best outcomes from intervention reported, were moderate levels of improvement.

269. Additionally, the bullying is rarely restricted just to the boundaries of school, but may also be part of non-school social contacts, clubs and societies, as well as less structured situations.
270. One must also appreciate that cyberbullying now forms part of the wider array of bullying affecting individuals.

Mini-Summary

271. Within the LGBTQ multiple sources show that mental illness, self-harming, suicidal behaviour and suicidal thoughts are surprisingly high
272. LGBT community 'attempted suicide' rates are between 20% and 53%, where 50% of this community have self-harming and suicidal thoughts and behaviour.
273. Nevertheless, one must consider the baseline to such behaviour, indicating that such thoughts and behaviour may be more common than is often appreciated, with young adolescents showing rates of 30%.
274. However, within the younger trans/GD community rates of self-harm are higher, with 90% thinking about killing themselves, while 72% have self-harmed at least once.
275. Moving beyond 'young people,' half of the trans/GD population have attempted suicide/self-harmed at least once.
276. Hence, when non-gender conformity is initially identified the local authority working with NHS providers needs to investigate the child and family and provide support.
277. Within school, anti-bullying policies, at best report moderate levels of improvement.
278. Most research appears to focus on Year 6 through to Year 10, developmentally the age of puberty.
279. Interventions need to address both environmental issues and issues within individuals, for both bullies and victims.

Developmental issues

280. In understanding gender dysphoria and transgender issues, in childhood and adolescence, there has to be an understanding of child and adolescent development. This should form the foundation for local authorities, placing the needs of children at the centre.

Decision-making: Youth

281. I will attempt to explain youth decision-making processes and the appropriate advice offered to young people and their families, from a research perspective.

282. The paper by Brown and Ward (2013), "Decision-making within a child's timeframe, ...evidence for family justice professionals," noted that the role of parents was significant in professionals' decision-making, while noting that risks for various 'maltreatment' were associated with parental learning difficulties and disability, mental illness, substance misuse and abuse.

283. Whereas this paper is predominantly focused on child mistreatment, there are nevertheless issues to be learned, and of relevance, within the LGBT community with younger populations.

284. The paper clearly cites that the nature of the relationships within the family home exerts an influence on social relations, mental health, and attachment style, affecting how children relate to others.

285. Further, that decision-making in youth need take into account parental views and as such within the field of 'gender dysphoria,' the wider family involvement must be considered, both in terms of positive and supportive efforts toward the young person, but also the negative.

Placing 'family' into child development

286. Child development is a process that continues well beyond birth and it is in the early years in particular that we see the formation of social relations. Yet far more happens, and it is now known that ages three-through-five years' are associated with the development of executive functioning, associated with working memory, mental flexibility, planning, social interactions and learning. Indeed, a 'disruption' in this period may have lifelong effects. Disruptions due to abuse and poor parenting or prolonged periods of illness, for either the child, or other close family members.

287. Further, child development in the early years has an impact on how the brain

functions, affecting multiple aspects of future behaviour.

288. However, 'child development' is not just about the child, but is a process that continues into adolescence and early adulthood. Indeed, the brain continues to develop well beyond birth, continuing for decades with the frontal and pre-frontal cortex not being fully mature until an individual has reached their mid to late twenties. Indeed, these centres of the brain are most closely associated with risk-taking behaviour and decision-making.
289. Hence, within this context, the family and the home directly affects the way in which young people think, the decisions they make, and the way in which they see themselves and others within a social world.
290. Of adolescence, Brown and Ward (2013) write: "Around the time of puberty the brain has a growth spurt in the higher regions which govern planning, impulse control, reasoning and the regulation and reaction to emotions. Prior to this growth spurt young people are more prone to engage in dangerous risk-taking behaviour and are not sufficiently able to interpret emotions, particularly if there is no secure attachment figure available to help them negotiate these tasks. This is because they rely on their more primitive limbic response (emotional) and lack the more mature cortex which can override it," p 47.
291. That is, there is acceptance that one need wait until adolescence until certain decision-making capabilities develop and that these need to develop alongside social factors, building on childhood, and the early relationships that provide the foundation for 'attachments.'
292. Yet this 'growth spurt' is a developmental process that occurs over a period of years and therefore takes time.
293. Within this statement by Brown and Ward, is the implicit need to consider family functioning and child rearing practice that may influence the development of future identity, including gender roles.

Adolescent decision-making

294. By way of starting the section on decision-making, one should consider the following 'abstract' from Nagel et al (2016),
295. "Adolescence is a unique time of change and challenge, when youths are set with accomplishing a multitude of developmental tasks necessary to transition to successful independent living and adult roles. Adolescents tend to be immature relative to adults in a variety of domains—biological,

cognitive, emotional, social—and must undergo significant transformation in these domains before reaching maturity. One notable example concerns juveniles' psychosocial immaturity—that is, deficiencies in youths' social and emotional capacities relative to adults. For example, adolescents are usually more impulsive, more likely to take risks, and more vulnerable to peer pressure than adults; they also tend to be more susceptible to stress and less able to weigh present benefits in the light of future consequences. These psychosocial deficiencies, compounded with still-developing cognitive faculties, contribute to adolescents' often immature and short-sighted decision making in a variety of domains, such as engaging in risky sexual practices or reckless driving"

296. This indicates the fundamental challenge to the transgender debate involving youths, their developmental status, and difficulty being able to see into the future and understanding how current decisions will affect their later life. Even legal adulthood often comes before adolescent development has completed and maturity achieved.
297. Daley et al (**2019**) looked at differences and similarities in family thinking toward such GD issues, noting that adolescents could not see beyond the short-term, worries about such issues as needles etc when considering the effects of hormone therapy. In contrast, the parents were concerned about the long-term consequences. It suggests that in decision-making, adults and adolescents have different priorities, the young person toward gender identity and its immediacy, whereas for the adult, they were concerned about the long-term impact of medication and the transition process. However, for both child and parent, the issue was ultimately about the outcome toward transition.
298. Nevertheless, it emphasises the need for a collaborative approach, parent and adolescent child working together, and the need to give time to the process involved in decision-making and the transition.
299. Further, it emphasises the need for the provision for both adolescent and parent, to have access to the correct information regarding 'risk.'
300. Decision-making changes as one continues through childhood, into adolescence and into young adulthood. Low working memory, higher impulsivity, and 'similarity driven decisions' are associated with childhood. Adolescent development sees an increase in working memory and a change from 'similarity driven decisions' to those involving 'task demands.' Indeed, children bias their decision-making judgements in a way that adolescence resolves, Martinez et al (**2018**). Hence, simplistically described, children tend toward doing what others do or say, while adolescents grow toward making

their own decisions and following their own directions.

301. However, what they also discovered was “Overall, children appear to not take advantage of advance information nor time to set up filters for their attention until late adolescence. This study contributes to our understanding of cognitive flexibility, a core function related to academic and life success,” p 1603.
302. That is, children can be provided with advice on risk, but still not be able to use it. Rather, it is during the process of adolescent development that they begin to utilise such information: an achievement of later adolescence.
303. One should also note, ‘childhood’ was determined ‘within this research’ by those aged up to 16 years of age, whereas adolescence was treated as part of young adulthood, aged 18 to 27 years.
304. Again, recent research indicates that substructures within the pre-frontal brain affect both cognitive and emotional control, being linked to age and maturation, Heller et al (2016). They emphasise the developmental issues connected to how one makes decisions and that professionals need to consider such issues when working with those who are as yet, developmentally immature.
305. Medical decision-making is a researched area, especially involving adolescence. In their paper, David et al (2018) considered a small sample, just 28 patients, where individuals had to make real world decisions, where life-changing consequences were involved. They found that where adolescent and parent/s were involved in the decision-making processes, their sense of ‘involvement,’ increased and lowered decisional conflicts. Further, the active involvement of the adolescent was not associated with confusion or distress. Hence, a collaborative approach was in the adolescent’s best psychological interest.
306. As a real-world example, it emphasises the social aspects of the decision that need to be made and the wider impact that such choices play on the social world of the individual and their family.
307. Yet as noted earlier, a disruption in the developmental processes early in childhood may have lasting effects. Hence, understanding the young person in the context of their past and their family history becomes an area of great importance, especially if the professional is to have trust in the processes and decision making of young people and their families.
308. Nevertheless, one of the challenges with transgender work and the wide

range of issues involved is the multidisciplinary nature of it and the ethical implications involved, such as disclosing confidential information from one professional to another.

309. Fivecoat et al (2017) considered these issues, focusing with the necessary multidisciplinary teams that have developed, especially for managing complex cases where both physical health and mental health overlap. They note, p 338, "The APA (2010; 3.05) guide....to refrain from entering into multiple relationships that are expected to impair their objectivity, competence or risks exploitation of the patient."
310. Whereas the APA ethical guidelines do not apply in the UK, similar guidelines apply here and as such, the safeguards in place must be considered when working across multi-professional groups, especially in extended teams where professional loyalties may influence decision-making.
311. Yet one may argue that the UK is in an especially good position, already having a history of multidisciplinary working, as shown through assessments under the terms of the Education Acts, 1981, and 1996, and the Children and Families Act 2014.
312. Making the decision to transition is not solely that of the individual, but involves families, friends, and multiple professionals.
313. Indeed, in such circumstances, one could argue that the decision-making process of the pre-operation transgender individual, the adolescent, needs protecting, potentially from parents, and professional/s.
314. Gardner and Steinberg (2005) considered 306 individuals in 3 age groups—adolescents (13–16), youths (18 –22), and adults (24 and older)—completing two questionnaires measuring risk preference and risky decision making, and one behavioural task measuring risk taking. Participants in each age group were randomly assigned to complete the measures either alone or with 2 same-aged peers.
315. Analyses indicated that, risk taking and risky decision making decreased with age; participants took more risks, focused more on the benefits than the costs of risky behaviour, and made riskier decisions when in peer groups than alone; and peer effects on risk taking and risky decision making were stronger among adolescents and youths than adults.
316. Therefore, younger individuals are more inclined toward risky behaviour and risky decision making than are adults and that 'peer influence' may also play an important role in explaining risky behaviour during adolescence.

317. One notes that 'peers,' can refer to the very support groups that can be helpful, but having their own pre-set agenda, may lead to poor decisions being made, that are not in the best interest of the young person, who is unable to see beyond their own immediate needs.
318. Hence, peers influence risk-taking behaviour. Further, such risks were more pronounced in adolescence (13 to 16 years) and youth (18 to 22 years), compared to young adulthood (24 years and older).
319. These are consistent with the findings of Martinez et al (**2018**), above, and consistent with what we now understand from brain studies and the development of the pre-frontal cortex.
320. This and other studies show the limitations with adolescent and youth decision making, and their susceptibility to 'outside' and potentially adverse influence, Amir et al (**2020**), Anyanwu et al (**2020**) Defoe et al (**2020**). Those with a vested interest will promote their own agenda and potentially minimise the well-being of others. Hence, in listening to adolescents and youths, one needs to be aware of peer pressures and the influence of outside agencies in order to balance the view of the young person and the potential influence of others.
321. However, one cannot simply dismiss the view of the young person, even when influenced by 'others,' but the balance should determine how family, friends and professionals respond.
322. Arguably, one of the more important papers on the topic of adolescent decision making comes from Icenogle et al (**2019**), due to a recent decision by the US Supreme Court concerning the legal status of juveniles and specifically, the research basis of when cognitive capacity, and when psychosocial maturity reaches adult maturity.
323. Using 5,227 individuals ages 10 to 30 years, the article "Drawing Legal Age Boundaries: A Tale of two Maturities" (July **2019**) comments:
324. "Grace Icenogle and colleagues explore the question: When are adolescents mature enough to consent to a medical procedure, drive a car, drink alcohol, or be eligible for the death penalty?"
325. In the United States, youth are legal adults at 18. Yet minors under 18 are permitted to make certain medical decisions for themselves or obtain a driver's license, while adults are prohibited from purchasing alcohol until age 21.

326. That said, age boundaries are in flux, and courts and policy makers are looking to developmental science for guidance on where to reset them. Indeed, citing developmental science, the U.S. Supreme Court has ruled that it is unconstitutional to sentence minors under 18 to death (*Roper v. Simmons*, **2005**) or to mandatory life without parole (*Miller v. Alabama*, **2012**).
327. Different legal matters require different capacities. For instance, making a decision about your health care necessitates deliberation, but resisting the urge to run a yellow light calls for impulse control. Icenogle and colleagues argue that the facets of psychological development relevant to these two situations develop along different timelines.
328. First, cognitive functioning, including the ability to deliberate and reason logically, reaches adult levels by around 15–16. This ability is particularly important for deciding, for example, whether to undergo a medical procedure, or consider who to vote for.
329. Second, psychosocial maturity, the ability to exercise self-control even in emotional situations, does not become adult-like until later, sometime in the 20s. This ability is important for exercising good judgment when considering whether to hold a young person to adult standards of criminal responsibility and permit them to purchase alcohol.
330. The authors note that most of the relevant developmental research has been conducted in the U.S., but to the extent that policy makers look to science for guidance, it is essential to know whether these age patterns are mirrored in other geographical and cultural contexts.
331. To explore whether US conclusions about maturity are generalizable, the authors examined the age patterns of cognitive capacity and psychosocial maturity using a cross-national study comprising more than 5,000 participants between 10–30 years from 11 countries: China, Colombia, Cyprus, India, Italy, Jordan, Kenya, the Philippines, Sweden, Thailand, and the U.S.
332. Results indicate that cognitive capacity in most countries reached adult levels in mid-adolescence, while psychosocial maturity in most countries did not reach adult levels until the 20s. Although there were some deviations from these patterns, the authors suggest that age trends observed in the U.S. are replicated in this cross-national sample.
333. Ultimately, these findings are consistent with the premise that youth are mature in some ways before they are mature in others. Put differently, young people may be mature enough to make decisions in the doctor's office,

which requires deliberation and logical reasoning, long before they are mature enough to exercise good judgment when drinking with their friends, which requires self-regulation.

334. Therefore, using two (or more) legal age boundaries is consistent with the developmental science."
335. One notes that this also builds on previous work involving the development of risk-taking behaviour and risky decisions, which appears to peak around late adolescence, around aged 19 years, and where this dual developmental system, though in many respects, over-simplistic, appears to be present across cultures, Shulman et al (2016); Duell et al (2018); Steinberg et al (2018).
336. Nevertheless, Icenogle and colleagues also caution, "Juveniles may be capable of deliberative decision making by age 16, but even young adults may demonstrate "immature" decision making in arousing situations," p 69.
337. Hence, the topic and the situation, surrounding and about which an adolescent is making a decision, may influence their ability, their capacity to act in a psychologically mature manner.
338. They conclude; "We argue it is therefore reasonable to have different age boundaries for different legal purposes: one for matters in which cognitive capacity predominates, and a later one for matters in which psychosocial maturity plays a substantial role."
339. The implications for professionals working with the gender dysphoric and transgender community is clear, one needs to provide the time and space for growth and development, understanding that adult related reasoning and decision making is not achieved until the mid to late teens through to the twenties.

Mini-Summary

340. Adolescence is the period of time beginning with puberty leading into adulthood, where legal adulthood arrives before adolescent development has been completed and maturity achieved.
341. Developmental decision-making processes change from childhood, through to adolescence and into adulthood. It is during this time that individuals learn to manage risks.
342. The management of risks is also a process that is social and related to family. Modern research indicates risky decision-making is weighted toward younger

people, highest in those 16 years and younger, but remaining high in those 18 to 22 years, and declining in those 24 years and above.

343. Further, the role of peers in such decision-making is not positive. The immediacy of the young person's needs is one of the primary issues determining poor decisions; they are largely unable to see the long-term picture, or the risks involved in their decision-making. Further, the younger the child, the more they tend toward doing what they and others want and do, rather than developing a mature and considered view.
344. A large cross-cultural study shows that there are two semi-independent systems connected to decision making, one cognitive, the other psychosocial/emotional, The former reflecting many aspects of adult reasoning, around 15 to 16 years, while the psychosocial matures in the 20's.
345. However, it is the combination of the two that may be needed in 'arousing situations.' Described more specifically by Icenogle et al (2019):
"Juveniles may be capable of deliberative decision making by age 16, but even young adults may demonstrate "immature" decision making in arousing situations," p 69.
346. Considering this alongside *Gillick*, one sees that the more complex the decision to be made, the greater the degree of maturity required. Hence, one need to be cognizant of a child and adolescent's impulsivity, the role of others, the bias toward risky decision making, and the difficulties being able to evaluate the long-term consequences of a proposed action.
347. Just as with driving and drinking, where limits are placed onto children and adolescents, so too does society need consider when and how far children can be allowed to decide on gender related behaviour.

Changing ones' mind

348. As any parent is aware, children can quickly change their minds, the nature and general direction of this process is primarily due to age, and its relationship to maturity.
349. In early development, children typically want to please and to be liked, especially by their parents. As they grow, their brain matures, and they become increasingly aware of others and the differences between them.
350. Increasingly, as they mature and grow toward adolescence it is their peers who they want to please, rather than their parents, as they move away from the values and attitudes of their parents and the previous generation. This is normal development.
351. However, when 'peers' are applied to transgender issues, there is often a 'political nature' to it. Hence, peer and social pressures are tinged with self-interest and not necessarily that of the young person, but the self-interest group to which they may aspire.
352. Nevertheless, the evidence suggests that many young people change their minds, progressing from one set of values and interests to another as they mature. Hence, in seeing themselves as different from the mainstream, potentially as a gender non-conforming youth, they may initially find connection with the values of one group, but developmentally, over time, they find themselves taken in another direction. That is, although children and adolescents may be diagnosed as gender dysphoric, their dysphoria might decline as they enter adulthood.
353. Wallien and Cohen-Kettenis (2008) studied 77 children referred aged 5 to 12 years, 59 boys and 18 girls, considering cross gender identification, discomfort with their own gender, and issues of gender roles.
354. Later, 54 of the children with an age range 16 to 28 years were willing to continue in the study. They re-examined the same issues. Of the original group:
- 30% were lost; either refused to continue or could not be contacted.
 - 27% continued to be gender dysphoric.
 - 43% were no longer gender dysphoric.
355. Hence, of those who could be traced at follow-up, 61% were no longer gender dysphonic.
356. Of the gender dysphoric group, nearly all indicated homosexual or bisexual

sexual orientation. Of the non-gender dysphoric group, all the girls and half of the boys reported having heterosexual orientation.

357. The conclusions of the researchers was that "most children with gender dysphoria will not remain gender dysphoric after puberty," p 1413.
358. Nevertheless, well over half of the original study group indicated a sexual orientation that was, by modern standards, within the average range, heterosexual, bisexual or homosexual.
359. Further, 'if we were to accept' the assertion that "most children," following puberty were no longer identifying as GD, then "most children" by the time they left secondary school during early-mid adolescence, would no longer require support for GD.
360. Drummond et al (**2008**) looked at the long-term development of 25 girls identified with Gender Identity Disorder (GID) aged 3 to 12 years, through to a follow up aged 15 to 36 years. At the time of the initial assessment in childhood, 60% met the threshold for GID as gender dysphoria was originally called, and 40% were subthreshold.
361. At follow up 12% were evaluated as having GD: the remained were either bisexual, homosexual, heterosexual or asexual. That is, 88% were no longer said to be gender dysphoric.
362. In looking at the data, the number of years between initial assessment and follow-up varied between 9 and 26 years. The minimum age at follow up was described as 15 years old which one might reasonably see as a flaw; an early-adolescent with some distance yet to travel before maturity.
363. Of greater interest was the sexual identity assigned. Of the 25 participants, 18 were assigned as heterosexual. Further, 88% reported "no distress with their female gender identity at follow up," p 39. The remaining 12% were living as, or perceived within the population, as males, though of these, there was an individual who "felt that, 'it was better to be neutral,'" p 39; hence, 4% asexual.
364. Of the 88%, "none of the participants desired contrasex hormones or sex reassignment surgery to masculinize their bodies, nor did they express a desire to get rid of their female sex characteristics," p 39.
365. One of the issues reasoned by Drummond' was the distinction between sexual orientation and gender identity. In essence, it was possible that GD was part of the developmental process toward a non-heterosexual

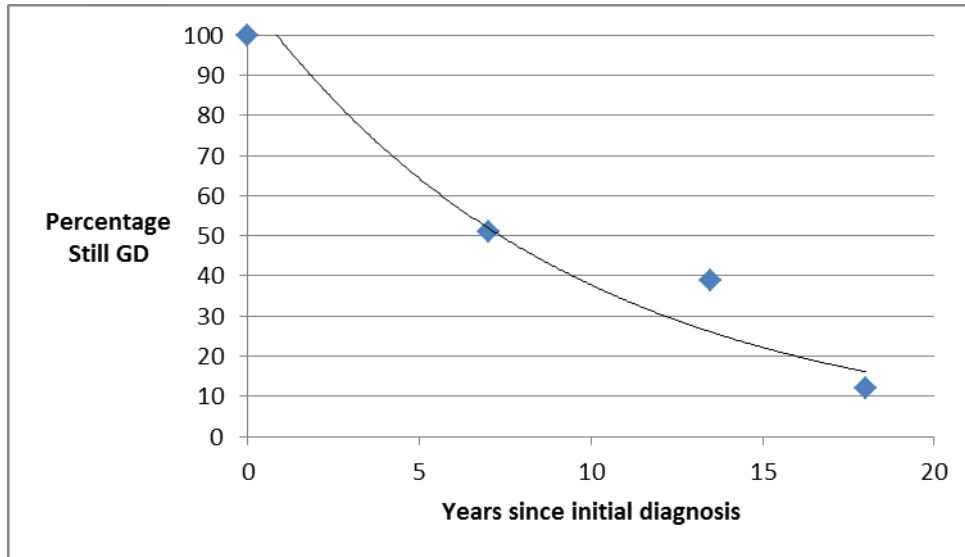
orientation in the future, within adult life for some, but not all. That is, they were 'non-gender conforming,' rather than gender dysphoric.

366. The evidence from within this paper suggested a developmental process that probably begins with a level of gender and identity non-conformity, not dissimilar to that experienced by many during adolescence. As one progresses through the development phase (i.e. adolescence), these difficulties resolve themselves for the majority with the focus on identity, social role, and sexual orientation. For a smaller group the GD issues remain, and as such, it suggests that one needs to give young people the opportunity to pass through the 'adolescent phase,' in order to find where it is they want and need to be on the spectrum of sexual orientation, preference, and gender 'identity.'
367. Wallien et al (**2007**) looked more widely at the development of GD in 120 children aged 4 to 11 years. They discovered that 52% of the children diagnosed with GD had at least 1 other diagnosed condition with psychopathology present in both girls and boys. Further, 31% of those diagnosed with GD also had anxiety disorder.
368. The researchers noted that multiple diagnoses and disorders made those with GD particularly vulnerable to social pressures as well as making the treatment more complex. That is, where does one place support, into the GD, into the anxiety, into the other psychopathology, and so on. Further, one also needs to consider the interaction between 'conditions,' connecting these in turn, to early childhood experiences and the effects of such.
369. This paper is particularly useful because it reinforces the vulnerability of adolescents, the developmental needs and the conflicts and difficulties that need to be resolved prior to adulthood. By ignoring or minimising the complexity of this developmental period, risks them finding their own dysfunctional solution: typically these focus on narrow, short-term benefits without a genuine appreciation for the future.
370. Steensma et al (**2013**) examined those under 12 years of age diagnosed with gender dysphoria and tracked them over several years. 127 young people were part of the study: 24 males and 23 females (47) persisted in their assertion of GD, while 31 boys and 15 girls (46) altered their views. In other words, approximately half of all young people originally identifying as GD, no longer identified as such. 28 adolescents did not respond to the follow-up.
371. At follow-up, boys were significantly more likely to 'change their minds,' compared to girls.

372. Those who were no longer assigned the label 'GD,' sexually orientated as, homosexual, bisexual, and heterosexual. Nevertheless, one must conclude, 49% of young people at follow-up changed their minds, no longer assigning as gender dysphoric.
373. Yet again it begs the question, is GD for some, part of a normal adolescent process whereby they discover their gender and sexual orientation?
374. Steensma et al (**2013b**) found that significant gender variance was 8-to-15 times more likely to be associated with the development of homosexuality in adulthood. One also notes that gender incongruence can be found at a rate of 15% to 25% for those under-12 years of age. That is, 'non-gender conformity' is very common and again, one might argue part of normal development for many. This was found in a study with 879 students.
375. This 'normative view' separates the diagnosis, moving it closer toward that of WPATH.
376. "Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, **2011**). Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, **1974**; Knudson, De Cuypere, & Bockting, **2010**). Only some gender-nonconforming people experience gender dysphoria at some point in their lives," p 11.
377. In essence, they have separated 'identity' from 'sex assignment.' 'Identity' is a developmental issue.

Percentage of Individuals Still Gender Dysphoric Over Time

The following was constructed by a colleague, but in a simplistic way, shows how the above may be understood.



378. There are four point from left to right. The point on the extreme left shows the moment in time when the person was 'diagnosed:' 100%. It represents the moment in time from when we start.
379. The next point, approximately 7 years on shows around 50% 'still GD;' Steensma et al (2013).
380. The next point, approximately 13-to-14 years on, shows under 40% 'still GD;' Wallien and Cohen-Kettenis (2008).
381. The final point on the extreme right, approximately 17-to-18 years on, shows 12% 'still GD;' Drummond et al (2008).
382. Given their age at initial diagnosis, the shape of the graph suggests a decline and change that may relate to normal development, appearing to show how the initial diagnosis is unstable over the longer term.
383. Kon (2014) states quite explicitly, " , it is important to note that many prepubertal children with GD may not require gender reassignment."
384. It is also consistent with the statement, above, from WPATH (2011), that not all who are non-conforming will progress to the status of GD.
385. Further, a significant number who initially 'persist,' in actual fact, are actually more likely to identify as homosexual in adulthood than as transgender

Mini-Summary

386. There is evidence that approximately 50% of those who are identified as GD in

childhood change their mind within seven years. This percentage increases the more time passes with the longest study showing 88% of children had changed their minds after a follow up of between 9 and 26 years.

387. Of those who 'change their mind' and no longer identify as GD, their chosen gender path, and their sexuality follows the normal range of options, some bisexual, some gay, many heterosexual. The majority choice regarding sexuality is to be heterosexual.
388. Given that many of those originally diagnosed with GD 'change their minds,' it suggests that diagnosis in childhood is unstable and therefore unreliable.
389. There appears to be a view that GD resolves itself for many by the end of puberty, though this may be optimistic with the 'resolution' taking longer for some.
390. Further, non-gender conformity may be common, and in turn, is part of normal development. That is, up to 25% of children may experience some form of 'non-conformity.' Yet most of these will not progress to genuine GD.

Treatment relies on assessment

391. Treating young people needs to be undertaken with great care, as any professional who routinely works with them will attest; ensuring that the condition/s treated are the right one, and that issues are addressed in the right order.
392. Although accurate diagnosis is difficult in many cases, for young people it is especially complex due to the effects of age and the differences in the degree of maturation between individuals.
393. Within education this was shown by the Bercow Report (**2008**) that identified that 60% of adolescents in special schools for those with behavioural problems also had speech, language, and social communication disorders.
394. Once this was understood, it begged the question whether professionals were treating behavioural difficulties as a primary problem, or were behaviours a secondary symptom of language and communication disorders? In essence, to what extent were young people acting out because they did not adequately understand the behaviour and communication of others. The answer to the question determines where the emphasis should be placed regarding treatment and support.
395. The misidentification of symptoms is also shown when one considers conduct disorder (disruptive behaviour), which is often found to be comorbid with depression and anxiety, Schweizer et al (**2020**), deRoos-Cassini et al (**2020**), Stepp et al (**2013**), Chorpita et al (**2013**). Treatment can be focused on the most overt and immediate difficulty, rather than the underlying cause. Hence, there is a surface level appreciation of the difficulty (i.e. conduct) and what appears to be a desire to suppress it, as opposed to addressing the root cause (i.e. depression) and thereby resolving the problem over the longer term.
396. Misdiagnosis is very common, as shown by Mokros et al (**2018**), finding that within the UK prison population, one-in-three diagnoses were probably wrong. Most UK diagnosis relies on the use of interview-based assessments.
397. Indeed, research dating back more than 70 years shows that professional agreement between two equal professionals who rely on interviews, may be as low as 50%, and between three professionals, as low as 20%, fading to far lower levels in some diagnostic cases, Ash (**1949**), Schmidt and Fonda (**1956**).
398. For the majority of those diagnosed with GD they will rely on psychiatry and the psychiatric, medical method of assessment and diagnosis. A psychiatric

assessment has three basic parts, a clinical interview, an observation of behaviour, known as a mental state examination, and a review of medical records.

399. Primarily, the diagnosis relies heavily on interviews, with the patient, and with family members. It is therefore a self-report assessment using a non-standardised, non-norm referenced approach; shown to be a less reliable assessment methodology by Meyer et al (2001).
400. Modern research shows that reliance on interviews results in low diagnostic accuracy. Aboraya (2007) surveyed psychiatrists for their opinion regarding psychiatric reliability:
401. "In response to the first question, whether psychiatric diagnoses are reliable or not, one clinician said psychiatric diagnoses are reliable (3.5%), three clinicians reported there was no evidence to support either (10.5%), and 24 clinicians stated that psychiatric diagnoses are unreliable (86%)," p 31.
402. Regarding why they felt the opinions and diagnoses were wrong they cited, "nosology (diagnostic criteria) factor (14.9%) ... patient factors (21.6%), and ... clinician factors (63.5%)," p 31.
403. Hence, even when one asks a range of psychiatrists why they do not agree and why reliability was poor, two-thirds identified the psychiatrist/clinician as the reason.
404. Regarding diagnosis and treatment, "reliability ... denotes the degree to which it produces stable and consistent results," p 84, Kankaras (2017).
405. Continuing, Baca-Garcia et al (2007) stated, "The results of our investigation raise worrisome concerns regarding the validity of results of epidemiological, clinical and pharmacological psychiatric research...p 216."
406. One might argue this is more of a concern when one understands that Baca-Garcia's paper was based on 10,025 psychiatric opinions involving more than 360,000 consultations.
407. In essence, what they showed was diagnostic reliability (kappa values) were often no better than 'fair;' which is now shown to be below an acceptable level.
408. Hence, one has to ask, how are medical decisions and diagnoses being made if interviews are unreliable and young people change their minds, as one would developmentally expect?

409. Further, Ross (2015) notes that the diagnostic criteria have significant problems, not least of which is the concept of 'gender incongruence/dysphoria,' which like 'homosexuality,' was seen as a mental illness, but is no longer viewed as such. The evolution of psychosexual disorders shown between DSM-II and DSM-5 reflect change and understanding, potentially reinforcing the view that GD is neither a disorder, nor is it a mental illness. However, because the diagnosis is based on a self-report and the criterion are loose and pay little attention to developmental issues for children, there remain significant difficulties with reliability.
410. Additionally, as well as the assessment process, the reliability of 'clinician's behaviour' is less than one might want to admit, First (2014), First et al (2014), Meder et al (2014), Mann (2019), Schildkrout (2019) and the degree to which others should be concerned is great.
411. The World Health Organisation, using European Union data, shows that medical errors are extremely common. Statistics available from 2020 cite, "medical errors and health-care related adverse events occur in 8% to 12% of hospitalizations." The WHO citing data from the UK, with further reference to France and Denmark showed adverse events in 10% of cases. Of course, this primarily relates to treatment issues, rather than diagnosis, where the situation appears to be of greater concern.
412. For the most part, assessments for GD are undertaken by multidisciplinary teams.
413. A paper by Butler et al (2018) describes the process of assessment for GD and whereas there are many excellent practices described there were some obvious contradictions. The paper states and implications are added... There is discussion about treatments being reversed and hence the need for fertility preservation. If a person needs treatment reversing, surely it raises concern over the initial assessment and diagnosis.
414. The effects of treatment, and reversing it, are not all clear. Hence, starting, stopping and trying to reverse the procedures have unknown consequences, which are being trialled on children and adolescents. Indeed, an evaluation of a centre for GD in Canada in 2015 noted how youths who began the transition process, then tied to 'reverse,' found the reversal process traumatising.
415. There is concern that treatments for GD will damage the individual, specifically noting bone loss, psychological damage, and reduction in energy as immediate effects of treatment.

416. Treatments with immediate adverse effects are being offered to young people, yet young people are unable to evaluate such risks or the impact of such a course of action; as also noted earlier, but see later as well.
417. Further, on this basis one must consider that treatment potentially contradicts *Gillick*, whereby the young person lacks the cognitive and intellectual ability, as well as the maturation required to make an informed choice, understanding the risks and their long-term implications.
418. The *Gillick* decision was clear, the young person had to have “the legal competence to consent to medical examination and treatment if they had sufficient maturity and intelligence to understand the nature and **implications of that treatment**,” [Emphasis added].
419. Of particular concern is the notion that there is psychological damage, with a population already showing high levels of psychopathology (mental ill health) and where suicide rates and self-harming are among the very highest in society. Hence, it is ‘being proposed’ that we allow the most psychologically vulnerable to make decisions to ‘self-mutilate,’ a decision that they may later come to regret?
420. Adolescents aged 16 years and over can consent to treatment. The distinction made between a youth 15 year and 364 days, and 16 years and 0 days is artificial. Whereas this may be related to wider issues of consent it does not follow guidance.
421. *Gillick* notes multiple levels of ‘competence,’ intellectual, the ability to make decisions, understanding, and wider developmental and emotional issues. However, developmentally, 16-year olds have only partial maturity in regard to decision making, and may be 6 to 8 years away from completing this developmental stage of adolescence.
422. Professor Sparrow CQC (2018) notes that although children are presumed to be able to give consent, parents continue to have a role.
423. However, as 16-year olds are not considered competent to drink, drive, or vote, or even acquire a tattoo. The idea that they can consent to treatment that could permanently disfigure them appears presumptuous. Indeed, one notes that the Children Act (1989) states that adulthood is reached aged 18 years,
424. Nevertheless, currently, drug treatments to stop puberty can be administered at the onset of puberty, in spite of *Gillick*. This presents the following dangers:

- a. The research into the safety of puberty blockers is not clear.
 - b. Off-label medication is being used, where the risks are unknown, according to the NHS
 - c. Without puberty, adolescent development cannot proceed. Adolescent development is not just the development of secondary sex characteristics, but affects a wide range of developments including cognition, psychosexual, psychosocial and so on. Developmentally, these are interconnected areas so interfering and/or damaging one may/will adversely affect others.
 - d. Adolescent development is not completed until the early twenties in young males and slightly earlier in young females. Therefore, puberty blockers followed by other off-label medication would have to be taken for a significant period. The consequences of which are unclear/unknown: cardio-vascular issues are noted, along with cancers and liver problems.
425. Quality assessments require the use of standardised tools, in order to complete a multimethod assessment. Such an approach improves the validity of the assessment, a process under stood for decades, Campbell and Fiske (1959), Meyer et al (2001), Wright (2011), Hopwood and Bornstein (2014).
426. Whereas structured assessments can be used, along with questionnaires they can also present with difficulties:
- a. Many standardised assessments tools often have limited validity; great care being required with the interpretation of their results.
 - b. Test selection is often poorly considered, which tests to use and why. This makes the information collected difficult to interpret. Conversely, if care is taken, then the data collected can be of importance
 - c. One needs to ensure the young person and read; can they read the questionnaires?
 - d. One needs to assess the language skills of the young person ensuring they understand what is being discussed; it is not just 'intelligence' that ensures this. Can they understand the language within the questionnaires, and can they understand the language used in the interviews?
 - e. Any failure to assess reading ability, accuracy, and comprehension may lead to an unreliable conclusion based on the questionnaire, Archer and Krishnamurthy (2002), Morey and Ambwani (2008).
 - f. The failure to assess language ability may lead to an unreliable conclusion based on interviews.
 - g. One also needs to consider if the questionnaire is a screening test or comprehensive. Their use and interpretation are very different.

427. Literacy and language development are key issues for all assessments:
428. Peter et al (2018) discovered that the reading level assigned to a questionnaire, and therefore suggesting its' accessibility, was dependent upon the way in which the assessment of reading was undertaken. They showed that tests/questionnaires assigned the same reading level could have radically different language requirements, sentence structure as well as a pre-existing need for (general and specific) knowledge.
429. Additionally, Coles et al (2017), of the Royal College of Speech and Language Therapists found similarly to Bercow (2008), whereby those with mental health difficulties also had significant speech, language and communication issues,
430. "It is acknowledged by the Endocrine Society that a young person under the age of 16 may not have sufficient psychological maturity to commit to such a lifelong and life-changing decision, and no evidence is available to understand the effects of giving gender-affirming hormone treatment before 16 years. A systematic review of the available evidence has been published recently by NHS England Clinical Commissioning Policy," p 635. Butler et al (2018)
431. However, there is evidence to suggest that many 16-year olds are not sufficiently psychologically or developmentally mature to be able to make such treatment decisions. Indeed, statistically speaking, that would, at a minimum, be one in every two 16-year olds; though this therefore leads to greater concern regarding pre-pubescent children.

Models of assessment

432. Two models of assessment will be shown here, that used by the GIDS Tavistock and Portman, and that used by the local authority. A brief mention of expert witness assessments for the courts will also be mentioned.

Gender Identity Development Service (GIDS)

433. Butler et al (2018) describe how the GIDS works for children and adolescents up to the age of 18 years, a service offered for over 20 years.
434. The clinic stated that it complies with guidance from WPATH (2012) and The Endocrine Society (2017).
435. The assessment notes that cross-gender behaviour needs to be present for at

least 6 months and may start in children between 2 and 4 years of age. Referrals are accepted for children 5 years and younger.

436. The GIDS acknowledges that 'gender diversity' is common in the cases referred to them. They state that assessments involve a multidisciplinary team with the initial assessment conducted by the psychology team. Specifically, it "is aimed at understanding the young person's development and gender identification in the context of their family background and life experiences," p 632.
437. It continues, "it takes account of how they feel about their gender and their body now and in the past, the context in which the gender dysphoric feelings arose and intensified, how these feelings are being managed in everyday life, and what hopes are held for proceeding in the future. A range of psychometric measures are used to assess behavioural and emotional functioning, including features of autistic spectrum disorder and self-harm," p 632.
438. Interestingly they then note, "around 35% of referred young people present with moderate to severe autistic traits."
439. "The assessment period usually takes 6 months or more over a minimum of four to six sessions. At the end of the assessment, it may be possible to confirm or exclude a diagnosis of GD," p 632.
440. At this stage a referral may be made to the paediatric endocrinology team; "for consideration of puberty suspension with a gonadotropin-releasing hormone analogue (GnRHa) when the young person fulfils the minimum eligibility criteria, such as Tanner puberty stage 2," page 633.
441. They continue,
"Once the paediatric team becomes involved, the child and family still continue regular sessions with their mental health clinician, and the two arms of the service work closely together," p 633.
442. Medical assessments are wide ranging, assessing full blood count, Iron/ferritin, U&E, LFT. Renal and liver function tests, bone profile, vitamin D, testosterone, oestradiol, follicle stimulating hormone FSH and luteinising hormone LH, prolactin, bone age in premenarchal female to male or prepuberty/inpuberty male to female, bone density scan.
443. The medical assessment follows a psychological assessment.
444. The paper acknowledges that hormone treatment can adversely affect bone

density. However, it also states, "GnRHa is the recommended first-stage medical intervention. This provides a physically reversible option to suspend sex hormone production, reduce the anxiety of ongoing physical development and allow further space for psychotherapeutic intervention and exploration" p 634.

445. The NHS, no longer agrees the notion that this process is 'physically reversible.'

446. The GIDS/NHS website:

Also note risks with cardiac events and potential difficulties if one wishes to return to the pre-treatment/natal gender. It acknowledges that risks in some areas of treatment are unknown.

447. The GIDS acknowledge that they see 16 years as the age of consent, p 635.

448. The diagnostic criteria on page 632 state:

- A strong desire to be of the other gender or an insistence that one is the other gender.
- A strong preference for wearing clothes typical of the opposite gender.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- A strong rejection of toys, games and activities typical of one's assigned gender.
- A strong dislike of one's sexual anatomy.
- A strong desire for the physical sex characteristics that match one's experienced gender.

449. Beyond Butler et al⁶:

"Assessment

If we accept a referral we endeavour to see the young person as soon as possible. Initially, we would offer them an assessment. **Our psychosocial assessment usually takes 3 to 6 appointments, and is with one or two mental health professionals from the team.** Assessment appointments are usually offered around every four to six weeks and **each appointment is usually for an hour.** We sometimes might offer longer appointments and/or see people less frequently depending on the needs of the family. [Emphasis added]

⁶ <https://gids.nhs.uk/about-us> - Downloaded, 16th September 2020

450. Assessments can be longer or shorter depending on a number of factors. Our specialist assessment is a wide-ranging one, aiming to explore and understand the child or young person's past and current gender identification, as well as their development across a number of areas of their life."

Local authority

451. I chose to use the assessment process of the local authority because it has a history dating back to 1981, with its latest incarnation structured around the Children and Families Act, (2014).

452. These are statutory assessments potentially leading to an Education, Health, and Social Care Plan (EHC plan).

453. Typically, they follow from an assessment conducted by the school, usually lasting a minimum of two years. During this time, other professionals from outside the school will be involved, often the educational psychologist, various medical professionals and possibly social services.

454. Where there is agreement across professional bodies, the local authority (LA) will be approached, provided with assessment information collected to that moment in time, and the LA will make a decision to initiate a statutory assessment or not.

455. The involvement of professionals has, by this time, typically covered two or more years.

456. Once initiated, a multidisciplinary assessment is conducted, the school, medical professionals, the LA educational psychologist, social services, with parental and child views being collected. Other groups involved may be approached for their views.

457. The assessment covers educational and learning needs, psychological and mental health, social, emotional and family needs.

458. The information is sent to the local authority who then determine if an EHC plan is required.

459. In most cases, a young person provided with an EHC plan will have been assessed over a period of at least two to four years.

460. Following this period of assessment, the LA determines, as an independent body, what the learning and developmental targets are for the young

person, and the provision required to meet them.

461. The EHC plan is reviewed annually, to make adjustment as the child grows, develops and matures.
462. EHC plans can be assigned to a young person to the age of 25 years.

Legal proceedings

463. For family assessments for the court, the psychologist is typically allowed 30 to 35 hours to assess a child and family, with 25 hours allowed for the assessment of a single child within the family unit.
464. By contrast in criminal cases, the Legal Aid Authority will allow a psychologist between 20 and 25 hours for the assessment.
465. In both cases, the time covers contact with the person at the centre of the assessment, child, adolescent or adult, time to evaluate all the evidence from the assessment and other sources, and court related paperwork, and so on; as well as time to write the report for court.

An initial view

466. One notes a few areas of concern with the GIDS, age 16 years being the age of consent with no reference to *Gillick*, safeguarding or 18 years being the age of adulthood.
467. Whereas 16 year olds can consent to medical treatment, one has to be cognizant that the issue of 'harm' is connected to such decision making.
468. A young person refusing life-saving treatment could be challenged and their decision over-ruled. Yet one might argue that 'rushing' toward treatment, prior to developmental maturity has the potential to be harmful. Are we to allow young people to make decisions that could have substantial long-term consequences to their physical health and to their mental wellbeing before they are developmentally mature?
469. Further, when one adds that 35% are assessed as having moderate to severe autistic spectrum traits, another way of saying, they have an autistic spectrum disorder that is known to interfere with the development of relationships via problems with social communication, as well as a sense of 'who one is,' relative to others. It would raise concerns over the safety of young adolescents within this service if such young people were medicated prior to the later stages of adolescent development.

470. This concern is further highlighted when considering research indicating at least half (most conservative study shows 49%) will, in essence, grow out of their desire to transition, while at the same time noting that the GIDS acknowledge 4-in-5 (73% to 88%).
471. How is the GIDS ensuring their duty of care?
472. Added to that, one sees the speed and brevity of the assessment, four sessions over six months, at which point a child or adolescent could be referred on to medical services for treatment with hormone blockers.
473. However, the NHS/GIDS website notes one-hour assessment sessions, and as few as three, in total. Whereas three one-hour sessions may be all that is required to dismiss the notion of GD, there is no sense of how the young person and their family then accesses other support.
474. Not having GD is one part of the young person's difficulties; the other is discovering what else the young person is struggling with, and who may help them.
475. The Butler' paper refers to Tanner's stage 2 puberty. This is used as a signal for accessing puberty blockers. However, this means children who start puberty early, could be taking such medication that interferes with adolescent development, not just puberty.
476. I would suggest the teams at GIDS had not considered such interactions, because they were stating that treatments were reversible. The NHS now acknowledges that this is simply not the case. Indeed, short-term use of the medication may provide irreversible changes. Hence, children do not have an opportunity to change their minds, at least, not without the risk of permanent damage.
477. There appears to be no reference to adolescent development and the changes from maturation, nor is there any overt acknowledgement of the way in which hormones interact during adolescence.
478. The WHO (2020) refers to such changes, and most psychologists who work with young people are aware, at least at some level, of these issues.
479. Just as the GIDS stated changes were reversible, it is acknowledged by the NHS that this may not be the case. Yet it is acknowledged that medication may affect bone density and that medication may increase risks of cardiac events. So is it unreasonable to suggest that the failure to consider the

interactions between the array of systems that change during adolescence may not be adversely affected by interfering with one of the central features of adolescence, puberty.

480. Simply saying, we don't know the effect, or the evidence is 'unclear,' might suggest a blasé approach to safeguarding.
481. Further, although there is acknowledgement of self-harming behaviour, neither the paper, nor the NHS/GIDS website appear to address the high levels of abuse and comorbid mental health needs found within the LGBTQ+ community.
482. Given that research shows, and acknowledged by GIDS, that many of the 4-in-5 who no longer conform to the GD diagnosis or require transgender treatment, proceed to becoming part of the LGBTQ+ community, it does appear remiss to 'not consider' how this highly abused group, many of whom have significant mental illness, are supported, beyond the GIDS.
483. However, I acknowledge that 'commissioning' within the NHS is a significant block to the effective access of resources.
484. Finally, there was mention of a multidisciplinary team, but not of working with outside agencies. This apparent omission may prevent access to important information from schools, social services, local authorities and so on.
485. The NHS/GIDS website notes multiagency working, while appearing to focus on CAMHS, another branch of the NHS, separated artificially via 'commissioning.'
486. As I am a professional experienced working within health (CAMHS; consultant grade Psychologist), social services (children with disabilities; head of psychology team), and education (Acting Principal Educational Psychologist/Head of Service; Deputy PEP) and have worked across professional boundaries, this notion of 'multiagency' suggested by GIDS is 'naive.'
487. If one contrasts this to the statutory approach, which as of necessity, is prescribed and detailed, one notes the emphasis on a multidisciplinary, multiagency approach to assessment.
488. Further, the LA itself is an independent arbiter in the process, each professional group independently assessing and passing on their findings and opinions to the authority, who then determine what happens next.

489. It is unclear how the GIDS interacts with social services, schools or others, but on the surface, this appears to be a significant omission affecting decisions being made at a time when the young people referred to GIDS are not developmentally able to make such decisions for themselves.
490. Turning to the diagnostic criteria, teachers and those who work with young people in school and education/care settings will notes the difficulties.
- A strong desire to be of the other gender or an insistence that one is the other gender.
 - A strong preference for wearing clothes typical of the opposite gender.
 - A strong preference for cross-gender roles in make-believe play or fantasy play.
 - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - A strong preference for playmates of the other gender.
 - A strong rejection of toys, games and activities typical of one's assigned gender.
 - A strong dislike of one's sexual anatomy.
 - A strong desire for the physical sex characteristics that match one's experienced gender.
491. Firstly, those under 6 (but occasionally up to 8) years may show some of the cross-gender behaviours noted above. They are 'common.' The behaviours usually resolve themselves between the age of 8 and 12 years.
492. Secondly, child rearing can produce, or assist in the continuance of some of the above cross-gender behaviours. As an example, who buys the clothes for the child? If the boy wears a dress, then it is his mother who buys it. Nevertheless, in general, the behaviours usually resolve themselves between the age of 8 and 12 years, though social services and/or CAMHS may be required to assist.
493. Yet one must remain open to the possibility that the behaviour of the child is being established, maintained, or deliberately developed by the parent/s. The child however, at an age of compliance (under 6 to 7 years), where the child often acts to please, may be oblivious to these actions or the motivations behind them. By the time the child reaches 8 or 9 years, the child's behaviour may be established by what may be a mixture of classical, when very young, and operant conditioning; supported by intermittent variable positive reinforcement, supplemented by the use of punishing reinforcers. This is the most powerful reinforcement schedule.
494. Thirdly, the notion that 'playmates' of the opposite gender, is somehow part

of the diagnostic framework suggests a failure to understand, families, individual personalities, or normal variations in behaviour.

495. Fourthly, safeguarding would be a concern, and a priority, especially considering the final two points above. However, this in large part depends upon the age of the young person. Differential diagnosis is essential, a process that takes time as many of the alternative diagnoses that could account for these two criteria have developmental aspects to them.
496. Fifth, the term, 'strong preference' is subjective and therefore allows for individual professionals to interpret information according to their own person standards. In essence, it reduces reliability. Further, as they are asking a parent and child, there is a reliance on them for an accurate and unbiased answer. However, as with all self-reports, there is a significant margin of error.
497. Finally, the criteria themselves are subjective, and because they do not make reference to developmental levels allow for almost any interpretation required, which in turn, does not help those who are rejected from the GIDS. Understanding why they are rejected will not make sense to them.
498. Professionally, although the details of 'precisely what they do,' is not entirely clear, I would, nevertheless, have concern referring on to this service.
499. As a point for further consideration, I noted above the way in which time was spent/required providing expert evidence; the time required for an assessment. Yet expert evidence according to The Criminal Proceeding Rules (2020) needed to be "objective and unbiased," (see part 19.2-1a). Yet further, the Forensic Science Regulator (Tully, 2019) states that opinions must be based on reliable and valid methodology.
500. Hence, the standards of the criminal courts are apparently higher than those required by the GIDS, which appear to be based on subjectivity, is open to bias, conscious and unconscious, and which may permanently disfigure young people.

Mini-Summary

501. There is evidence that both medical treatment and initial diagnosis carry significant risks.
502. There is evidence that medical treatment carries health risks, both in the immediate and short-term, and over the long-term; acknowledged by the GIDS and/or the NHS.
503. According to GIDS and/or the NHS/GIDS website, assessments may be as short as three sessions, each lasting no longer than an hour, although one acknowledges that many will be longer than this 'minimum.'
504. Based on the 'minimum,' the primary assessment methodology used in the diagnosis of mental health, clinical interviews, are known to be, and largely accepted as, unreliable. There are multiple issues with the poor methodology, including the behaviour of clinicians, problems with the diagnosis of conditions themselves, the use and choice of assessment tools, and more.
505. This situation is more complex due to the subjective nature of the diagnostic criteria used. It reduces the reliability of the assessments.
506. The notion of 'age of consent' and its connection to assessment does not appear to be consistent with *Gillick* or the developmental level of adolescence.
507. *Gillick* competence requires a higher standard when the issues to be addressed are complex. One might argue that using off-label medication where the outcomes are uncertain and the long-term dangers in many cases, unknown, make this a complex area upon which decisions need to be made.
508. Potentially harmful and risky decisions are required by young people prior to developmental maturity; for those referred to the GIDS.
509. Treatment with medication may begin as soon as puberty is detected, Tanner's stage 2. This could place the young person into primary school.
510. Puberty is an essential part of adolescent development.
511. One must acknowledge these opinions, in part, are based on an academic paper by the GIDS, and the NHS/GIDS website. There will be limitations in what they describe and as such one must take the initial views above, and this mini summary, as a preliminary opinion open to modification, and where necessary correction if required.

Is there a risk from the professionals themselves?

512. The above indicates that, Professionals often lack the ability to accurately and reliably diagnose, for a variety of reasons.
513. The diagnosis of gender dysphoria in young people is unreliable and appears to confuse two separate conditions, gender dysphoria and non-gender conformity. At least half of those identified as GD will no longer identify as such as they progress through puberty and into adolescence.
514. However, those undertaking the diagnosis and passing the young people on toward treatment acknowledge that around 4-in-5 will not require such treatment due to their progression through adolescence.
515. The decision to begin treatment at Tanners stage 2, prevents/delays the onset of puberty. Even the short-term use of this medication may lead to irreversible changes in the child.
516. One immediately sees that if 4-in-5 will not require treatment as they progress through adolescence, yet treatment can start at the onset of puberty and hence 'before' adolescence has begun, signals a contradiction and indicates a significant risk in the clinician's decision-making.
517. In general terms, 'any diagnosis' is most reliable when, (1) Symptoms are at their most extreme, enabling a differentiation between conditions, and (2) where a profession as a whole, rather than individual practitioner, has had many years' experience identifying specific conditions.
518. Hence, years of professional experience, by an individual practitioner is not enough; what one needs is an agreement by the profession as a whole, to say what a condition looks like, when presented with a patient showing 'symptoms.'
519. However, as one moves away from rare and/or 'extreme symptoms,' and those that readily differentiate between conditions, diagnosis becomes more complex, reducing professional agreement.
520. In this case, 4-in-5 'changing their minds,' along with the NHS warning of the risks suggests 'red flags' are being presented by the profession.
521. Difficulties and challenges have been present for many years. Meehl (1954) identified that psychiatric risk assessments has no greater accuracy than 50%, or that of a coin toss. Indeed, Meehl is credited with being responsible for

developments in 'forensic risk assessment,' and the use of alternative methods, such as 'actuarial methods' and 'the structured professional judgement.'

522. In looking at Ash (1949), he found diagnostic agreement between psychiatrists was as low as 20%. Hence, clinicians from the same profession, assessing the same individuals, using the same diagnostic criteria, only agreed the diagnosis one in every five cases.
523. More recently, surveying psychiatric opinion and reliability, in a small study, Aboraya (2007) indicated that 96.5% of psychiatrists who were asked could not guarantee the reliability of their profession in diagnosis.
524. If one then returns to gender dysphoria, one must first ask, who is undertaking the assessment of the children, the adolescents and the adults?
525. One could, or perhaps should argue that one needs expertise, not in a specific 'condition,' (e.g. GD), but in being able to differentiate different, similar conditions and how they show themselves developmentally, as the young person grows and matures.
526. Further, these professionals need to understand the limitations of their role, the accuracy, and reliability of their diagnostic opinions, and to be aware of the changes shown in young people due to normal development.
527. As the majority of gender dysphoric children no longer fulfil the diagnostic criteria, reflecting part of a natural and normal adolescent development, then this may, or one could say, should affect the advice offered to young people and the support services.
528. Allied to this is the probability that the medical professional conducting the assessment may simply, 'get it wrong.' Indeed, the 'error rate' as noted above, is high within the medical profession, and has been noted in the field of psychiatry and psychology for decades. Indeed, if up to 88% of young people no longer conform to their previous diagnosis of GD, it reinforces the view that early diagnoses are unstable and unreliable; or simply reflect diagnostic error.
529. However, the role of the professional is well shown by First (2014) and First et al (2014) noted how practitioners typically decided on a diagnosis in the first 5 minutes of meeting a client, then spent the rest of the session looking for evidence to prove it. Further, they did not use the diagnostic algorithm (diagnostic manual/DSM) in a structured manner, and hence, typically used their own criteria as the basis for diagnosis; not the official, internationally

agreed one.

530. Of course, this second point is particularly interesting given the loose nature of the diagnostic criteria themselves.
531. However, it was not just First and colleagues observing this, Samuel and Bucher (2017) noted how clinicians alter their diagnostic opinions “based on the demographic features of the client,” p 107.
532. Professor Michael First, psychiatrist, above, worked on DSM-IV, DSM-IV-TR, DSM-5 and was/is lead in coordinating ICD-11 with DSM-5. One might argue that his opinion has some value.
533. Nevertheless, one must conclude that the probability of misdiagnosis is higher than the professionals may want to admit, even when one is using multidisciplinary teams as opposed to individual practitioners.
534. Advising young people, families, schools, and local authorities is far more complex than is admitted when the reliability of the diagnosis especially in childhood is so ‘unstable.’
535. However, added to the fact that diagnosis is unreliable and hence treatments may be used with the wrong patient, there appears to be little scientific understanding of the long-term effects of the treatments offered.
536. Analogous was the advent of birth control where in the early years the use of such medications as oestrogen, and progesterone had notable side effects. It took years for their long-term side effects to be recognised, accepted, and managed.
537. However, early work showed some concern for the role of cross-sex hormones especially in transfeminine members (born male, trans-female), with pronounced differences from cisgender regarding venous thromboembolism (VTE), and ischemic stroke. That is, evidence is developing that suggests that for some, there may be an increased risk of an acute cardiovascular event, Getahun et al (2018).
538. Further, in a literature review by Patel et al (2020), they considered the risks of long-term ‘hormone replacement therapy’ on transgender patients, using evidence-based reports published since 2000. They state,
539. “We conclude that the long-term effects of off-label pharmaceutical use for modulation of hormone levels and sexual characteristics in transgender patients have not been well studied. The tendency of steroid hormones to

promote the growth of certain cancers also raises questions about the safety of differing doses and drug combinations. Further clinical and laboratory study is needed to better establish safety and dosing guidelines in transgender patients."

540. In other words, children, adolescents, and young adults are being exposed to medical practices that are not yet based on scientific evidence and medication is being used without knowing the risks to the patient.
541. On this one issue alone, it suggests that prescribing doctors are acting outside their expertise. 'Acting' when one does not know the potential harm being done by those actions, and the risks to the patient, is unethical. It begs the question, why do local authorities, who have a duty of care to young people, allow children and adolescents to be exposed to such practices, and why do they allow school children and their parents to demand that schools make 'adjustments'?
542. Local authorities are allowing adjustments based on poor scientific evidence and that may be harmful.
543. Further, according to the NHS, March **2020**, they state, "Hormone therapy will also make both trans men and trans women less fertile and, eventually, completely infertile. Your specialist should discuss the implications for fertility before starting treatment, and they may talk to you about the option of storing eggs or sperm (known as gamete storage) in case you want to have children in the future. However, this isn't likely to be available on the NHS. There's no guarantee that fertility will return to normal if hormones are stopped."
544. Whereas it is immediately obvious that this statement is aimed at an adult audience it nevertheless begs the question, does a child understand these concept of fertility?
545. Indeed, if 'treatment' could start at Tanner's level 2, the onset of puberty, how might that affect access to eggs and sperm, as well as their long-term storage?
546. Further, do young people understand that there is no guarantee that fertility will return to normal if hormones are stopped?
547. Do younger people understand that 'treatment' may not be reversible?
548. Further, as noted earlier, the NHS is already aware of many of the dangers and uncertainties with the medical treatment of GD, and the risks to young

people.

549. Again, it brings the reader back to *Gillick*, and more specifically Lord Scarman regarding the child demonstrating "sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions."
550. One of the implications is once treatment is started nothing may be the same ever again, no matter what future choices are made. Once started, you may not be able to turn back.
551. However, in considering implications and risks, *Gillick* is not just an issue for children and those undergoing the process of adolescent development, but the professionals and the actions they take.
552. I deliberately repeat, according to the GIDS, around 4-in-5 young people identified with gender dysphoria will no longer identify as such as they progress through puberty and adolescence.

Mini-Summary

553. The diagnostic criteria are understood to be limited, and as such, those diagnosing need to be experts in the practices of assessment and diagnostics, as well as similar conditions to GD, to aid differential diagnosis.
554. Decades of research has shown that interview-based assessment methodologies and processes are unreliable. Those diagnosing need to be aware of assessment research and what increases the reliability of findings, not just for GD, but other similar conditions or conditions that may present at a surface level as similar, but derive from a different source.
555. Based on scientific evidence and consensus, the stability and reliability of the GD diagnosis in childhood and adolescence is poor, making any decisions on such, seems very risky. Considering the World Professional Association for Transgender Health, WPATH (2012), 'GD' appears to be more than one condition, not all of which proceed to be recognised as 'true gender dysphoria' which may require treatment at some level in the future.
556. One notes that treatment outcomes are poorly assessed and hence, risks are not, as yet, adequately understood. Unfortunately, what makes this more of a concern is that this applies to the treatment of adolescents and in some cases, children.
557. What is known is use of the current medication may place members of the

transgender community at increased risk of future heart attacks, strokes, and cancers. Further, as suggested by some experts, the dosage of medication offered and required is unclear as are the interactions between medications.

558. The NHS, who provides the treatment for many in the transgender community, recognises there are many aspects of treatment where the risks from medication are unknown.
559. The NHS, who provides the treatment for many in the transgender community, acknowledges that once started, the effects of treatment may not be reversible.
560. Prescribing where the dangers are, unclear or unknown and where research appears very limited, may be considered unethical.
561. One must consider, or ask, why are local authorities and others offering advice unsupported by the scientific evidence and where it has the potential to do harm?

The reliability from research

562. There are numerous limitations with GD research, but probably well shown by Chen et al (2018). They noted a range of issues that one needs be aware of when considering transgender and non-gender conforming youth (TGNC).
563. Firstly, there is broad agreement in the research that young people move away from gender dysphoria as they progress through adolescence. Chen et al suggests a conservative figure of 'at least 50%' may be useful, though research suggests this may rise well above this as one progresses toward, and through, later adolescence.
564. The rates at which children no longer fit with diagnosis, along with modifying the 'added numbers,' has been factored into this paper, along with the progression over time.
565. Further, Chen and others ask, if a significant proportion of young people 'change their minds,' or rather, grow and develop during normal adolescent development, no longer identifying as gender dysphoric, then one need identify the markers that differentiate between these young people from those who remain.
566. These markers either do not exist, or at the very least, are unclear and as such, any treatment prior to the end of normal adolescent development reaching into the late teens and early twenties may be pre-emptive, and potentially harmful.
567. One may ask if/when treated 'too early,' and damaged as a result, what recourse do young people have.
568. I note that the age of adolescent development is not assigned by 'years,' or words such as 'teens.' In this case, it is, in large part, assigned by the maturation of the brain, the pre-frontal cortex, cognitive systems, and the endocrine system, as well as the associated cognitive and social-emotional developments that accompany such.
569. In young women, the pre-frontal cortex and the endocrine systems are 'developed and mature,' by late teens to early twenties, whereas for young males, it is later - mid-twenties. Similarly, social-emotional development broadly follows the same pattern, while cognitive pathways precede social-emotional ones by around two years.
570. The pre-frontal cortex is important in risk-taking behaviour and decision-making. Until mature, the decisions of adolescence may reflect the

immaturity in such systems and the levels of impulsivity associated with it. Indeed, from an ethical perspective, if one wishes to ensure that decisions are developmentally appropriate, one must consider not just the stated view of young person, but also their maturity; a view that I would propose is consistent with *Gillick*.

571. Chen et al, do not use developmental biology or psychology as the basis of their decision-making, but what they call 'legal majority,' the age of 18 years. That is, the age we know to be one of risk taking for both male and female adolescents. Interestingly, Butler et al (**2018**) in the UK use 16 years, an earlier part of adolescent development.
572. However, it is also clear that Chen is concerned that decision making to begin procedures is often without the agreement of appropriate experts and professionals in adolescent development or mental health. Hence, one might argue that the professionals' decision-making regarding when and how to proceed in the management of gender affirming surgery (GAS) is constrained by their lack of training, experience, and knowledge in the development of adolescence.
573. Put simply, adolescent development does not support the idea that 16-year olds are of sufficient maturity in what is a highly emotive area, to offer consent to treatments, that in turn, may prove to be irreversible and/or harmful.
574. More specifically, Kaltiala-Heino et al (**2018**) expressed concern regarding the treatment of adolescents for gender dysphoria, with some starting puberty suppressing treatment before 16 years even though adolescence is understood to be a time of change, one involving identity, psychosocial and psychosexual discovery.
575. One need consider that puberty is not a process solely about secondary sex characteristics; it is not just about the genitals.
576. More specifically they state, "Consolidation of identity development is a central developmental goal of adolescence, but we still do not know enough about how gender identity and gender variance actually evolve. Treatment-seeking adolescents with GD present with considerable psychiatric comorbidity. There is little research on how GD and/or transgender identity are associated with completion of developmental tasks of adolescence," p 31.
577. In simple terms, we do not fully understand how and why we change as we do during adolescence. We do not fully understand the individual developmental differences regarding both gender, and sexual orientation

and preference.

578. Further, we know that those with GD have multiple mental health problems and there is no reliable evidence to indicate why or how this combination of issues is best managed or treated where necessary.
579. Of course, with this background, it brings into focus the treatment and 'life adjustments' allowed with preadolescents, with children. By altering the way in which they live their lives, allowing cross-gender name changes, changes with clothing, use of toilet facilities and so on, one may be pre-empting changes that naturally occur and denying normal gender variability in younger people, noted earlier.
580. Additionally, although we know that a majority of those who begin exhibiting what outwardly appear to be GD behaviour and preferences in childhood grow out of this state later, we do not know why or how they continue to develop as they do into their middle years.
581. The World Health Organisation (2020) describe adolescence (see appendices) and note several interesting developmental processes:
- Puberty is starting earlier in many countries, although in general the timing of menarche has levelled off in high income countries at 12–13 years.
 - Biological changes during adolescence do not all start at 10 years or stop at 20 years. Some important endocrine changes start before age 10 while some neurodevelopmental changes that take place during adolescence continue into the early twenties.
 - Underlying these physical changes is a wide spectrum of endocrine changes (gonadarche and adrenarche), including hormones that affect gonadal maturation and the production of gonadal sex steroids.
 - The growth spurt during early and mid-adolescence is regulated by the complex, inter-related production of **a number of hormones**.
 - Hormonal changes, such as the regulation of oxytocin and vasopressin, also may affect how adolescents interact with others.
 - **Important neuronal developments are also taking place during the adolescent years**. These developments are **linked to hormonal changes** but are not always dependent on them
 - Biological maturity precedes psychosocial maturity and, to some extent, **there is disconnect between adolescents' physical capacities, their sensation seeking and their capacity for self-control**. [Emphasis added]

Mini-Summary

582. If maturity is not achieved until the late teens and early to mid-twenties, it raises concern regarding the ability to consent, in the terms of Gillick,

especially school children, but even more-so for those in primary school.

583. Further concern is raised noting that critical treatment decision-making in the UK begins aged 16 years, and in other countries aged 18 years. This is well before the completion of adolescent neurodevelopment.
584. Research shows that the completion of adolescence signals the ability to manage risk, and to make decisions that are balanced.
585. Indeed, the processes of maturity and of adolescent development are not fully understood and as such, interfering with such processes may do more harm than is currently understood.
586. Many hormonal and neurodevelopmental areas are interconnected and the idea that one area can be isolated without affecting others appears risky, if not dangerous.
587. One of the key areas of concern is the notion of providing puberty blockers to children and adolescents, as if puberty and the development of secondary sex characteristics was an entity in and of itself, separate from other processes seen in adolescent development.
588. Impairing puberty potentially affects other aspects of adolescent development, including the development of the brain, associated hormonal/endocrine systems, and the way cognitive and social-emotional systems develop.
589. Adolescent development is a time of multiple inter-related changes affecting neurocognitive development, social emotional development, and psychosocial functioning. The development of these areas is linked to hormonal changes.
590. Further, hormonal changes also affect physical changes, not only linked to gender and secondary sex characteristics.

Gender identity: normal developmental processes

591. There is a view that there are strictly, two genders, male, and female. However, the way in which one defines gender and gender roles is a product of culture and society, and strictly speaking, not just external genitalia.
592. Hence, if there are around 600 biological differences separating males and females, including the external genitalia, then one also need add these social and cultural ones as well.
593. Indeed, the way in which some diseases and clinical conditions develop also show gender differences, reflecting underlying biological differences.
594. Yet the hundreds of differences may, socially and culturally be off-set by the way individual characteristics develop and therefore one can never be seen as wholly a product of biology.
595. One sees that not all men are 'hypermasculine,' with an exaggerated stereotyped behaviour, emphasising strength, aggression, build, and sexuality, or that all women are hyperfeminine. Indeed, the characterisation of such is set within a social construct and typically fails to acknowledge the wide range of what is considered masculine and/or feminine. It also fails to acknowledge the wide and overlapping gender roles that exist in many societies and cultures, and the way that personality characteristics impact on behaviour and the roles one adopts.
596. Hence, one sees variants within a 'gender type' as well as individual personality traits and characteristics.
597. In such a case, character variations broadly refer to the concept of 'androgyny,' the combination of male and female characteristics expressed in regard to gender identity, gender expression and/or sexual identity, and the way these impact on how an individual interacts within their social world.
598. Much of the early work into androgyny was undertaken by Sandra Bem (**1974, 1977, 1981**), a person whose work is credited with improving equal employment opportunities for women in the United States.
599. However, her research showed that all individuals had male and female characteristics to a greater or lesser extent. That is, men also had female characteristics, and women had masculine characteristics, irrespective of their sexual orientation and preference.
600. Hence, while 'sex' is primarily binary, either male or female, how one

expresses masculinity, and femininity has a high degree of variability. This is normal. Bem suggested that it was the balance of these 'gender characteristics' within an individual that contributed toward higher levels of good mental health

601. Evidence to support Bem's early work can be seen from researchers such as, by way of example, Aube et al (1995), Juster et al (2016), and McKenzie et al (2018). It is of interest that the work of Bem also has overlapping features with the concept of gender non-conformity and indeed, may reflect similar processes.

Mini-Summary

602. Although there are two sexes, male and female, the expression of gender characteristics varies greatly. Both males and females show characteristics more normally associated with the opposite gender; this is normal.
603. Gender characteristics are also a product of the social world and the culture in which an individual is raised.

Trauma: Gender and sexual minority

604. "Emotional abuse, emotional neglect, physical neglect, and total combined maltreatment exposure may be risk factors for adolescent identity diffusion," p 65, Penner et al, (2019).
605. That is, child abuse affects the development of 'adolescent identity,' and subsequently, affects adulthood.
606. Parents, stepparents, and carer-givers are the main abusers of children. The same adults are the ones asked to agree medical procedures, including transition. Those from the LGBTQ+ community report experiencing high levels of childhood abuse.
607. However, Penner et al are clear that abuse leads to identity diffusion, rather than integration, where integration is a process that occurs 'for the majority' of those who have not been abused during adolescence. Integration is the coming together of multiple systems during the process of adolescence, gender, sexuality, social, cognitive and so on, leading to the development of the young adult and their sense of self-identity.
608. Yet for those who are non-gender conforming, not all adverse effects of abuse appear evenly spread, by that, one refers to differences between men and women. "For men higher levels of childhood non-gender conformity predicted experiences with childhood trauma by an adult family member, which in turn predicted the higher prevalence of sexual victimization," p 496, Bos et al (2019).
609. Interestingly, Bos et al focused on those who as children, were non-gender conforming and as LGB adults had same sex-attraction, where their conclusion was that work was needed in developing greater acceptance of non-gender conformity, which may in turn, reduce childhood trauma, and sexual victimisation among gay and bisexual men.
610. One notes the overlapping themes from the work of Sandra Bem on 'androgyny,' in the 1970's. The theme that perhaps non-gender conformity is a form of androgyny, where the characteristics and personality traits normally characterised and associated with one gender are present in the opposite gender and this in itself is part of the normal range of behaviours.
611. Briefly, in the UK, around 570,000 women and 100,000 men aged 16 to 59 years reported experiencing sexual assault by rape or penetration during childhood, ONS (2016b).

612. Charlton et al (2018) noted how young women from sexual minorities (bisexual and lesbian) are around twice as likely as heterosexual peers to have a teen pregnancy. Using this as a starting point, they looked for risk factors. One of their key findings was that, "reaching sexual minority developmental milestones earlier was also associated with an increased teen pregnancy risk," p 1.
613. However, underpinning this was bullying and childhood maltreatment (victimisation) prevalent among the LBG-(TQ) communities, related to some extent with sexual orientation discrimination. More specifically, the transgender community reported higher rates of abuse in childhood, leading to greater risk of mental deterioration, Fontanari et al (2018).
614. The research consistently refers to 'abuse,' but not necessarily sexual, or related to 'gender,' but all types of abuse endured by young people from the LGBTQ community.
615. Forde and Duvvury (2017) note dominance in the research toward women who have been victims of sexual violence, whereas, by comparison, the research in sexual violence against men has been lacking, with the possible exception of the prison population, data stretching back more than 20 years, see Harlow (1999).
616. In a small-scale study involving adult men where 80% were sexually abused as children, and 40% as adults the findings noted a range of 'survivor issues,' and difficulties with gender and gender roles. Indeed, the authors note, "sexual violence strikes at the very heart of what it means to be a man in the eyes of a patriarchal society," p 307. Hence, the diffusion of identity and gender are both connected, at some level, to the abuse that occurs during childhood, and by implication, may have a role of in the difficulties of those with more extreme forms of non-gender conformity.
617. Indeed, Saketopouou (2014) raised the idea that transgender patients may have been subjected to 'massive gender trauma,' and as such, their very nature was associated with 'misgendering.'
618. More specifically, it was the intersection between the mind, the body, and culture that influenced this process. Hence, treatment need consider issues of body dysmorphia, where it is suggested that the body had not become 'mentalised' by the child; an area often ignored by therapists. "Attention to unconscious fantasy and its transformations shows the importance of helping transgender patients whose bodies are a source of suffering to be able to psychically represent their pain as a critical step in the process of a psychologically healthy transition," p 773.

619. In essence, those who are transgender need to develop a mental picture of their body as is, and a body as desired, noting that realism for any possible body, or future body, will not match their fantasy, their ideal.
620. Of course, where one has been abused, making sense of 'the body' and being able to 'mentalise' what it is, may be a significant challenge. The process is not wholly about the body and body image, but simplistically, also what the body represents within the self, others, and the associated experiences and expectations from within their society and culture; being set within the history and experience of the individual.
621. Although the ideas of Saketopouou have not been widely adopted, coming from a psychotherapeutic rather than medical model, it raises the interconnection between different aspects of how individuals from the GD/transgender community present, and the challenges that need to be resolved.
622. In essence, it is not simply about the body, and believing that they are in the wrong body/gender, but about a wider self-image that also needs reflect their experiences, and the abuses that many will have suffered.
623. Piegza et al (**2014**) presented a single case study involving GD. Specifically, the authors present a woman, "whose internal problems connected with her sexuality and incomplete identification with the role attributed to her gender originate from her family history. Long-lasting, traumatic experiences of incestuous abuse and violence on the part of close relatives disturbed her development in many areas of personality and functioning," p 135.
624. In essence, they present a person damaged at multiple levels due to the long-term sexualisation and violence endured. The "patient unambiguously identifies herself as a woman," p 135. However, they suggested that in supporting this patient, it was a multi-level intervention, not only addressing GD and her desire to "become like a man," but multiple aspects of long-term trauma, perpetrated by her own family.
625. Daniolos and Telingator (**2013**) described a trans-male (born female) diagnosed GD, "being trapped in the wrong gender was longstanding, pervasive, and deeply rooted in his identity, including extensive cross-gender role interests and behaviours," p 1245.
626. This individual had a chaotic lifestyle as a child and responded by acting out and self-harming. However, they state that it was the combination of psychopathology, allied to the gender dysphoria, which needed separating

and investigating.

627. Specifically, they suggested, “clinicians must listen to the child who presents with gender discordance in an effort to understand how a multitude of biopsychosocial factors may be affecting identity issues and coping styles and resist premature interpretations,” p 1245.
628. In simple terms, clinicians need to slow down, listen to the client and begin the process of understanding the life of the individual, and how they cope with the multiple issues, events, and challenges from within their lives.
629. UK statistics based on the 2015 – 2016 Crime Survey (ONS, **2016b**): the latest available, gives data that is based on a face-to-face survey and a self-completed questionnaire: for those aged 16 to 59 years confirms:
630. “The survey showed that 9% of adults aged 16 to 59 had experienced psychological abuse, 7% physical abuse, 7% sexual assault and 8% witnessed domestic violence or abuse in the home. With the exception of physical abuse, women were significantly more likely to report that they had suffered any form of abuse asked about during childhood than men.”
631. “Perpetrators were most likely to be a parent for those that had suffered psychological abuse (father, 35% and mother, 40%) or physical abuse (father, 39% and mother, 29%). In contrast, survivors of sexual assault by rape or penetration reported that the perpetrator was most likely to be a friend or acquaintance (30%) or other family member (26%). For other types of sexual assault, the perpetrator was most likely to be a stranger (42%). For sexual assault by rape or penetration, male victims (15%) were more likely than females (4%) to report that they had been abused by a person in a position of trust or authority, such as a teacher, doctor, carer or youth worker.”
632. “Women were significantly more likely than men to experience sexual assault by rape or penetration (including attempts) during childhood. This equates to an estimated 567,000 adult women aged 16 to 59 having experienced this type of abuse during their childhood, compared with an estimated 102,000 adult men aged 16 to 59.”
633. These figures are both interesting and disturbing. In essence, they suggest 670,000 adults were raped as children, equating to 1% of school children.
634. Hence, in a school of 1200 students, 12 have, or are experiencing sexual abuse.
635. In understanding this, one can see how the research into identity and gender

'diffusion' may signal the challenges for some young people.

Mini-Summary

636. Rates of child abuse endured by the LGBTQ community are very high and as noted earlier, as are difficulties with mental health. Indeed, it is highly likely that the two issues are related.
637. However, though related, researchers indicate that time is required to separate the issues in order to address them appropriately.
638. Child abuse interferes with the development of identity and hence, to the way in which the young adolescent and adult develops.
639. Such trauma also connects with gender, with aspects of abuse striking at the heart of its development, strongly affecting adolescent development.
640. The perpetrators of such abuse are overwhelmingly parents and caregivers, who are interestingly, the same people who contribute toward offering opinions regarding medical treatment.
641. As a point of clarification, there is little/no reliable evidence to show that abuse 'causes' GD.
642. Further, there is no evidence that gender dysphoria can be 'fixed,' though one needs to be cautious because therapy, assessments and time are required to find those who have a genuine need to transition, from those who do not.

The concept of 'Reversibility'

643. One of the issues to consider when assessing a young person is that of fantasy, for example, what they will look like and how their life will be different after the use of medication and/or transgender surgery. Fantasy and reality are different sides of the same coin and because we already know that surgeries do not always produce the results desired; issues that take time to resolve.
644. However, alongside this is the notion of 'what if I don't like it, can I go back to what I was?' Again, this is a developmental issue, but also an issue of intellect and cognitive ability. Do they understand what 'reversibility' really means?
645. In addressing this area, one immediately notes that the NHS warn, above, that once treatment begins, even if stopped, there is no guarantee that an individual will return to their pre-treatment state.
646. Bullens and van Harreveld (2016) note that within the population in general, there is an expectation that decisions' can be reversed. However, research actually shows that so-called reversible decisions offer lower levels of choice and higher levels of regret. In other words, what can be achieved when one reverses an earlier decision is not necessarily what is desired, and the outcome of such a process may be less satisfying than hoped.
647. The concept of reversibility is actually affected by cognitive abilities and motivation, influencing the decision to 'reverse,' or not, and the understanding of what 'choice,' to act or not, or to later reverse, might really mean.
648. For the transgender community, they are often highly motivated to engage with a change process, which in itself risks clouding their ability to see the risks and the difficulties that may develop in their future life, especially with young people.
649. As one matures, so cognitive and emotional limitations become manageable, potentially reducing the ability to interfere with rational thought while improving the understanding of complex concepts.
650. One notes that being highly motivated can be very useful in overcoming challenges, but at the same time, for those who are younger, when focused in the wrong direction, can become an obstacle.
651. Hence, as a process, reversibility is affected by maturation, understanding the risks and benefits, and by motivation, potentially clouding the ability to reason.

652. Subtle negative effects include difficulties with employment, widely accepted as a reality within the LGBTQ community, in spite of legislation that tries to prevent it. As noted by the LGBTQ community and website, (lgbtq+ot.com, 2018), "workplace dress codes, bathrooms, and culture can be problematic for LGBTQ+ employees."
653. Hasan et al (2016) using a 'human-machine system' looked at what constitutes the best decision and the 'dissonance' between the alternatives and choice made, along with outcomes from that decision.
654. Not unsurprisingly, "the result shows that the final decision has less dissonance and more satisfaction when users get the chance to reverse the decision." That is, people are less conflicted or concerned when making a decision if they believe that the decision can be reversed at a later date, if their original decisions/action does not work out as expected.
655. One immediately notes the risks, that of fantasy and false belief, believing that decisions can be reversed and restored either in part, or to their pre-decision state in its entirety; a situation that for the GD community may be exacerbated by unreliable professional advice.
656. Hence, it is both a developmental and a cognitive-intellectual issue that the medical professional always needs to consider in full; 'consideration' takes time for children and adolescents.
657. As noted above, the choices are often less than wanted, and the level of regret greater than anticipated or understood at the time when the original decision was being made.
658. Hacenberg (2010) followed four 12-year olds, to see how they approached a series of problems where anticipatory factors were required, along with multi-stage processing, including the use of reversibility.
659. She discovered that the four students did not, at the same age and in the same establishment, have, or use the same strategies to solve problems, which is not surprising. Indeed, two students were able to use anticipatory problem-solving approaches while only one could use reciprocal relationships; reversible thinking (aged 12 years).
660. This suggests, as is already understood, that the concept of reversibility is developmental, but also connected to cognitive intellectual functioning.
661. Further, placing Hasan et al (2016) and Hackenberg (2010) together one sees

- that *Gillick* is correct when it suggests that decision-making need take into account intelligence and maturity. How can children and adolescents with poor skills in reversibility and the concepts around their actions to transition, make decisions until such time as they have matured.
662. Ikram et al (**2020**) using what they described as 'above average' young people aged 18 to 22 years (undergraduates) explored reversible reasoning, finding that there were three different approaches. However, the wider findings were interesting.
663. Students need to understand the issues and concepts being discussed if they are to see the value or difficulties with the concept of reversibility. Put simply, if they do not have sufficient understanding, intellect, or experience, they will struggle to make an informed choice. Telling them over-and-over and enabling them to provide the 'right answer' to the question, does not indicate understanding.
664. By way of example, allowing young children, for example, to cross dress, then expecting the rest of their community to 'adjust,' when the children have insufficient understanding, intellect, and experience of what they are doing and its impact on themselves and others, might be considered irresponsible.
665. Part of the concept of 'understanding' is to firmly grasp the implications of an action or series of actions. This is a higher order thinking skill often related to the Piagetian concept of 'formal operational thinking,' which children typically develop from age 12 to 14 years, (as indicated by research) the beginning of secondary school, progressing through to adulthood
666. It is the ability to think in an abstract manner by manipulating ideas in their head, without any dependence on (practical) concrete manipulation (Inhelder and Piaget, **1958**); though one cautiously notes that 40% of 'college freshmen' never achieve this, connected to educational attainment and cognition, Geary and Bjorklund (**2000**), Anderson (**2003**), Genovese (**2003**).
667. The research suggests that the idea that adolescents can 'grasp the implications of an action or series of actions' may be optimistic.
668. That is, decisions being asked of children and adolescents may be beyond their ability to realistically understand what the future will look like, for them.
669. More specifically, if the child 'changes gender dress code,' and re-dresses in a gender conforming manner, it will not result in responses from others that were consistent with their pre cross-dressing behaviour; other children will not respond as if the cross-dressing never happened.

670. GD children and many younger adolescents will not understand this response from others, blaming others and making what may already be a fragile mental health more vulnerable. That is, it will be difficult to return to their pre-decision state, reversing their own decision and behaviour, but not necessarily that of others.
671. Further, Ikram et al found that some of the strategies used were simple, described as putting on socks, then putting on shoes then taking off shoes then taking off socks; a simple, two-stage process. However, the more complex the problem, the more complex the thinking and reasoning to understand the processes and the concept of what reversibility may mean. Hence, capable young adults (18 to 22 years) resorted to simple 'reversibility,' when the issues were more complex and required high order reasoning.
672. In applying this to the transgender community, one cannot so simply give a young man his penis and testicles back or a young woman her vagina and breasts after the operation to remove them. Hence, reversibility from a personal perspective (the TG individual) will require an understanding of the additional risks of surgery as well as the body looking different again, should reversal surgery be sought.
673. Developmentally, this is a difficult concept, addressing not only the body, but also the mental state of the individual and their psychosocial standing within society; see Daniolos and Telingator (2013) and Saketopouou (2014) above.
674. Whereas young children, of primary school age may be non-gender conforming, and/or they may show characteristics more often associated with the opposite gender, a higher level of androgyny, allowing them to insist on a transgender process so early, may inhibit their natural psychosocial and psychosexual development.
675. Although a small selection of research has been cited, it is clear that understanding some associated concepts to enable decisions to be made is developmental and complex.

Mini-Summary

676. The concept of reversibility is developmental and multifaceted.
677. Reversible decisions are often not as they at first appear. What can be achieved is not necessarily what is desired by the choice to reverse, and the outcome of such a procedure may be less satisfying than hoped. Reversing earlier decision is often with a restriction of later choices; achieving and going

back to what was may be impossible.

678. The issues required regarding reversibility are also connected to cognitive and intellectual functioning. Hence, it is possible that some individuals will struggle to fully understand the choices and limitations with their actions. This is consistent with *Gillick (1985)*.
679. Primary school children do not have the cognitive capability to fully comprehend the transitional processes and will not fully appreciate the implications of their actions on others.
680. Understanding 'reversibility' appears connected to the Piagetian concept of 'formal operational thought.' This is developmental beginning for those who achieve it from 12 to 14 years of age, though research suggests that not all people develop this higher level of thought.

DISCUSSION: Summary

681. Based on the reviewed evidence, and applying the principles of *Gillick*, it is clear that there are specific limitations on what young people can reliably consent to.

682. Whereas this is set out above, developmental psychology suggests that those under 18 years are being asked to consent when there is little prospect that many will understand the nature or implications of treatment.

Diagnoses are often unreliable

683. As discussed above, many GD diagnoses have shown themselves to be unstable. Trying to decide on the minimum age to start treatment, presents with a number of difficulties:

- a) Half of all young people initially diagnosed will develop and no longer conform to the diagnosis seven years later, though it could be more than 4-in-5 as more time passes.
- b) The assessment criteria themselves are weak and open to considerable subjective judgement. Therefore, deciding who has GD and who does not, has an added level of unreliability.
- c) WPATH (2012) notes how for many of those initially assigned a label of GD, or more appropriately, non-gender conforming, do not proceed to treatment and/or surgery. Hence, the world group of experts into gender dysphoria acknowledge these difficulties.
- d) One of the difficulties in those who are younger relates to the confusion between GD, and non-gender conformity: the differences are difficult to distinguish with no clear guidance for professionals at this time.
- e) Further, cross-gender characteristics and personality traits are part of normal development. Such issues typically develop and resolve themselves during adolescence and early adulthood; this is normal. Hence, any diagnosis needs to allow young people to progress well into adolescence.
- f) The assessment processes themselves need to be placed into context where some described reliability in terms of "worrisome concerns," Baca-Garcia et al (2007) and reliability being, "poorer than the field (psychiatry) has tended to assume," Gowensmith et al (2013).
- g) The behaviour of the clinicians themselves, irrespective of the diagnostic

criteria are also of concern, as shown by Aboraya et al (2006), Aboraya (2007), First (2014), First et al (2014), Meder, Mayrhofer and Waldmann (2014) Samuel and Bucher (2017)

- h) One notes, there is the claim that assessments are multidisciplinary, which in large part may be accurate. However, when they involve as few as 3 one hour sessions, it raises doubt about the quality of what is undertaken, especially for such a complex issue.
- i) As the diagnosis appears to have a developmental aspect, one has to ask how such a rapid diagnosis can be assigned when in part one needs time to see how symptoms develop. Indeed, schizophrenia spectrum disorder in young people develops as a young person progress through adolescence. Clinically, the evidence for such developments across many disorders and areas of difficulty is well-established.
- j) One also notes that diagnosis for gender incongruence/dysphoria is in large part, a self-report diagnosis. There are high rates of reporting error in symptoms via self-report.
- k) Therefore - For primary school aged children, any diagnosis is likely to be either unreliable, or unstable. Any treatment decision could be a risk to the child.

The effects of the diagnosis/treatment are potentially irreversible

- a) As noted by the NHS, the process of transition involves changes, many of which are largely irreversible, even prior to them being taken to their ultimate surgical conclusion. Therefore, the decisions taken must be based on maturity, with full knowledge and understanding of the risks.
- b) The NHS acknowledges that treatment change via medication may be irreversible after only a short span of time.
- c) Developmentally, 'reversibility' is a complex concept and as such, care is required because some, or even many, may believe that transition is a reversible and risk-free process.
- d) Further, the long-term effects of some elements of treatment are unknown, as acknowledged by the NHS. Yet some research is indicating the possibility that some may be harmful. Specifically, the medication used is off-label with evidence to show an increased risk of cardiovascular events, bone density change, and the development of cancer.

- e) The risks with the use of off-label medication are not well established. Safe dosage of such medication is unclear.

Risks that the professionals pose to children

684. Great caution is required when considering the diagnosis of GD, because the professionals themselves form one of the risks to the young people.

- a) It is a sad and well-established fact that doctors often make mistakes. Medical errors are common within hospital medicine.
- b) World Health Organisation (2020): "medical errors and health-care related adverse events occur in 8% to 12% of hospitalizations. For example, the United Kingdom Department of Health, in its 2000 report, an organisation with a memory, estimated about 850,000 adverse events a year (10% of hospital admissions). Spain (in its 2005 national study of adverse events) and France and Denmark have published incidence studies with similar results."
- c) Regarding GAS, short-term surgical issues are common, including pain and the need for further operations to redress issues from the first operation.
- d) Even though the research shows the diagnosis is unstable and unreliable, medical professionals still chose to proceed toward treatment, which may be unnecessary and/or inappropriate.
- e) Professionals appear to use unreliable methods to arrive at a diagnosis and subsequent recommendation to treat. Yet potentially of greater importance, they appear to allow themselves the opportunity to rush their diagnosis.
- f) The diagnosis is ultimately based on self-report, an assessment method of high error and bias.
- g) Risks not only include those from medication, surgery, friends, and others in society, but also additionally from the young person and their immature level of development.
- h) Professionals treat, even though the children cannot give developmentally or intellectually appropriate consent.
- i) The belief that "it may be possible to confirm or exclude a diagnosis of GD," on just 3 or 4 sessions, with the implications that that carries, is a concern.
- j) The leading UK GIDS centre acknowledges that up to 88%, as noted in this paper, will not continue with the transition process, yet it is still recommended

to proceed with medical treatment, even though the NHS itself acknowledges there are unknown risks.

- k) Local authorities should caution schools that 'as many as' 9-in-10 children (88%) will change their minds regarding GD when they reach puberty and progress into adolescence.
- l) This also raises concern that 'social transitioning' early, may have psychological consequences for the child as they progress through school.

Cornwall School Transgender Guidance

From the website:

685. "Cornwall Schools Transgender Guidance has been written in collaboration with The Intercom Trust, Devon and Cornwall Police, Cornwall Council and Head Teachers. It is the first of its kind within the UK to be incorporated into schools and colleges, specifically aimed at supporting Transgender pupils and students." Cornwall.gov.uk 21/07/2017

686. They continue: "It is a pioneering piece of partnership working showing that Cornwall can be at the forefront of making improvements in understanding and supporting pupils and students that identify as Transgender who are in education"

687. It was produced, and edited by The Intercom Trust and Cornwall Police. The working group had three local authority officers, and two head teachers.

Evidence of a research base

688. There is no overt evidence that the document was supported by a research base.

689. There are no academic references cited within the document.

Upon what is the document based?

690. There is a section on legislation, citing the Human Rights Act (**1998**), The Gender Recognition Act (**2004**), and The Equality Act (**2010**).

691. The document then proceeds to move into the topic of 'discrimination,' and the role of the Equality Act (**2010**).

692. The document shows little or no evidence that developmental issues have been considered within the guidance:

- There is no mention of normal adolescent development;
- There is no mention of the role of puberty;
- There is no mention of the process of adolescent development;
- There is no mention of hormonal changes affecting behaviour and decision making;
- There is no mention of hormonal changes interacting with cognitive development;
- There is no mention of the development of decision-making and risk-taking behaviour.

693. There is no mention of normal sexual development involving:

- Sexual identity (LGBTQ+, and 'straight');
- Gender identity;
- Identity of 'the self';
- Normal variability in gender and sexuality.

694. There appears to be no guidance on how to keep children safe 1.

- From poor decision-making;
- From risk-taking behaviour;
- From exploitation.

695. There appears to be no guidance on how to keep children safe 2.

- Working with specialist centres, such as the GIDS, Tavistock and Portman NHS Trust;
- With doctors who may seek to prescribe;
- Ensuring the centres and their professionals have appropriate background information.

Support for early transition

696. The document, either inadvertently or otherwise, appears to promote early medical intervention for students:

697. Page 15

"For example, it is highly likely that in football, no physical advantage would be gained in participation at the age of 11-12, but by the age of 15-16, there may be significant differences which may need to be taken into account. In certain circumstances some **pupils or students may be in receipt of hormone blockers** which may affect performance and eligibility for competition." [Emphasis added].

698. Page 17

"A girl's school which permits **a pupil who is undergoing gender reassignment** to remain after they adopt a male gender role would not lose its single-sex status." [Emphasis added].⁷

699. Page 19

"Trans pupils and students are often told to use the 'accessible' facilities rather than those for their **true gender**." [Emphasis added].

⁷ (Taken from - Department for Education, March 2012, "Equality Act 2010: Advice for School Leaders, School Staff, Governing Bodies and Local Authorities", 2.2 'Single-Sex Schools')

700. Page 22

“Changing name is a real indicator that the Trans pupil or student is taking steps to, or proposing to move towards a gender they feel they wish to live in. It is possible to change a name on a school or college roll or register for a preferred name and when sending details of young people to exam boards. Students can be entered under any name with an exam board. However, once a result is accredited it will need to be linked with a Unique Pupil Number (UPN) or Unique Learner Number (ULN) which existed in the school census information submitted in January of the exam year. UPNs and ULNs are only linked with legal names *, not preferred names. It is possible for exam certificates to be issued in the preferred name.”

701. “*Legal Name refers to the name in which a pupil or student arrives in education for the first time; this is often the name on their birth certificate.”

View

702. There appears to be nothing within the guidance, the Local Authority ‘Policy’ that shows any recognition of normal development, either in regard to being straight, or from the LGBTQ+ community. Understanding normal development would enable schools to understand the limitations with where in the developmental processes their students lay.

703. Further, it might also allow appropriate support, knowing that many who identify as Trans will, over time ‘change their minds,’ no longer conforming to or identifying with the diagnosis of GD. Hence, students would then need to address the process of adjusting their social standing, their interpersonal relationships, with their ‘new’ sense of gender identity and sexual orientation.

704. Understanding normal development could enable schools to offer a more flexible approach to the support required.

705. There appears to be no recognition that, as acknowledged by the GIDS, Tavistock, ‘up to 88% of students will no longer conform to the diagnosis of GD and/or require treatment.’

706. One notes, in my assessment, I have used the far more conservative figure of 49%/half of children and adolescents. However, I also concede that there are other researchers who have suggested figures beyond 90%. If GIDS uses the range 73% to 88%, one might reasonably suggest that at least 4 in every 5 children will no longer conform to GD, or move toward transition.

707. The focus on ‘Trans,’ within the guidance is as one might reasonably expect, but it shows a simple and one might argue, uneducated acceptance that

what the child says (self-diagnosis) as reality. Whereas the young person may be 'non-gender conforming,' or show some level of gender variance, this is not the same as GD and/or Trans. One might argue that an acknowledgement of this requires schools to be more flexible in their thinking, understanding that what a child or adolescent is going through is part of a normal development for many, a process that may change as the young person matures.

708. There is nothing regarding diagnosis, and the necessary concerns the local authority should have regarding the protection of children and adolescents. There is also a failure to acknowledge difficulties with the diagnosis itself.
709. Research appears to have been ignored in favour of wider government policies, though in a manner that appears to ignore wider issues, such as *Gillick*. Indeed, the source material for the Cornwall documents appears to be restricted to The Human Rights Act (**1998**), The Gender Recognition Act (**2004**), and The Equality Act (**2010**). There is no mention of the Children Act (**1989**), or of the CQC or NICE, all of which have a direct bearing on how one supports young people in educational facilities.
710. The guidance in schools appears to deny by omission, that early interventions, medication, changing names and so on, may do irreversible harm, and students who chose to progress down this path need substantial monitoring and support.
711. Further, the medication used is off-label and potentially dangerous over the long term, and where surgery may not produce the outcome desired by the young person and is largely irreversible.
712. The NHS acknowledges concerns, whereas the Cornwall guidance omits any reference to such.
713. The failure of the Local Authority to provide appropriate warning and guidance associated with such indicates that those producing the document were unaware of the complexity of GD and the research surrounding it.
714. The Cornwall guidance appears to omit the concept of 'safeguarding.' There is no guidance offered regarding the need to develop anti-bullying policies and practices to support those from the LGBTQ+ community within secondary school.
715. The document, in offering guidance to schools, appears to focus on rules and regulations and not the wellbeing of the children and the processes that they need to address during adolescent development leading to adulthood.

The initial questions posed

Developmentally, is there a minimum age, below which a child will be unable to make decisions concerning their gender.

716. 'Gender typing,' what a gender looks like and what we 'expect,' is established within cultures, such as the type, and colours of clothing, being one example. Hence, within a 'western culture,' boys wear blue and girls pink. However, some girls prefer blue and some boys pink. Indeed, culturally, pinks and reds used to be the colours of men in the past; associated with the high cost of their production and as such, primarily available to men only.
717. The majority of parents will make allowances for young children wearing colours normally associated with the opposite gender and playing with toys of a similar vein. The behaviour itself is normal.
718. Hence, developmentally, children are making 'gender decisions' from a very young age, often, but not always, supported by their parents.
719. However, one need to be aware, for many children the gender stereotyping of clothes, colours, and toys is determined in large part by parents and as such, extremes of gender behaviour, may be supported by parental behaviours.
720. One cannot blame parents, because packaging of such items is also designed to influence the behaviour of the parent, as well as the child. Hence, extremes of gender behaviour are also affected by multinational companies.
721. However, one must also accept that if a boy aged 3 years is wearing a dress, it is the parent who is buying it, and in the process, setting up a psychological expectation within the child of what is normal for them?
722. Developmentally, any social conflicts that may be found with such 'preferences' resolve themselves over time, as the child matures. This development is often associated with an increase in social contact, attending nurseries and infant school.
723. However, until such time as social contacts increase and develop, it is common to find children determining their own gender associations and behaviours, supported by their parents and the parent's decisions and choices.
724. Yet where children continues to act in cross-gendered ways one must place

the child's welfare first, their social standing within their community, their relationships with others, their sense of developing self-image and self-esteem, their mental health.

725. If a parent was placing the welfare of their child at risk in any other circumstance, safeguarding would be the priority.
726. Cross-gendered behaviour within a school setting carries risk for the child. The younger the child, the less they will be able to consent to that risk.
727. Over time, as social contact increases, so one sees differentiations develop between genders, simplistically, due to social interactions, societal norms associated with the child and their family and the process of maturity.
728. Nevertheless, in nurseries it is common to see boys mimicking their mothers' behaviour when playing with or alongside others in the (play-) 'house.' By 6-to-8 years of age, gender differences are often established, though not necessarily 'set.'
729. Developmentally. It is around the age of 8 years that children are moving away from wishing to conform with and please their parents, and move towards a wider social influence.
730. One needs to appreciate that 'gender' is a developmental process, connected to maturity and to society, and as such, the decisions that need to be taken by the child are primarily determined by outside influences and their developmental age.
731. One must also consider the LGBTQ+ community report very high rates of victimisation and abuse, of all types, all of which affect the development of self-identity.
732. Developmentally, the key decisions regarding 'gender' rely on an individual progressing through puberty. Puberty addresses both neurocognitive and social emotional development, altering how one sees oneself and one's place in the world.
733. Puberty occurs in the early stages of adolescent development taking around four years. Adolescent development takes between 10 and 12 years.
734. The prevention of puberty has the potential to interfere with adolescent development and the processes required to become a fully functioning young adult.

735. The World Health Organisation (2020) describes the role of adolescence and the multiple psychological and psycho-social processes that the young person needs to go through. Puberty and adolescence directly affect the brain and its development. Interfering with such processes has the potential to do great harm.
736. Indeed, research involving Eastern European athletes, indicates that altering hormones during adolescence causes long-term health problems.
737. Taking into account the complexity of the diagnosis, and the problems and concerns with treatments, it indicates that under the terms of *Gillick*, no-one under the age of 18 years, a young adult (Children Act 1989) would be capable of making a decision regarding 'treatment.' See below.
738. However, taking into account what we know about adolescent development, many of those making the decision to proceed with treatment for GD, aged 18 years, will not fully understand the risks.

Can a child's desire to transition to the opposite sex result from factors (psychological or otherwise) other than gender dysphoria?

739. As shown by the evidence, the definition of gender dysphoria is 'problematic,' being imprecise and so loose that it appears to be meaningless. Whereas 'gender dysphoria' from the APA, DSM-5 (2013) is a better, more flexible diagnosis, than the WHO ICD-11 (2018) definition, it nevertheless appears to ignore normal developmental processes.
740. Further, one must consider what a 'child's decision to transition' really means.
741. Children, of primary school age, lack the decision making capacity, the intellect and understanding regarding gender, sexual orientation and preference and a sense of 'self,' to be able to transition; they lack the necessary level of maturity; these are processes directly connected to puberty and adolescent development.
742. According to *Gillick* (1985), and the CQC (2018):
743. "...whether or not a child is capable of giving the necessary **consent will depend on the child's maturity and understanding and the nature of the consent required**. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent" [Emphasis added].

744. This was cited in/by NICE, 2019. The CQC (2018) note: The right of younger children to provide independent consent is proportionate to their competence - **a child's age alone is clearly an unreliable predictor of his or her competence to make decisions.**" [Emphasis added].
745. *Gillick* refers to: "They must be able to demonstrate sufficient maturity and intelligence to understand **the nature and implications of the proposed treatment**, including the risks and alternative courses of actions." [Emphasis added].
746. *Griffith* (2016) notes: "**Gillick competence is a functional ability to make a decision.** It is task specific, so **more complex procedures require greater levels of competence.** It is **a high test of competence that is more difficult to satisfy the more complex the treatment**, and its outcomes become." [Emphasis added].
747. Hence the first thing that is needed is consideration of the ability to consent.
748. Given *Gillick's* high test, which appears to have been minimised by professionals, one must conclude that no child or adolescent could consent to treatment:
- a. The young person needs to understand the immediate social effects of the transition process; the implications of social change;
 - b. The young person needs to understand the issues and risks in using off-label medication;
 - c. The young person needs to understand that treatment, even in the early stages may lead to irreversible changes in the body; the implications of what this might mean for them over the long-term;
 - d. The young person needs to understand that many processes cannot be reversed; again, this addresses the long-term implications for the young person;
 - e. The young person needs to understand the long-term issues associated with the use of medication;
 - f. The young person needs to understand the short- and potentially long-term effects of surgery;
 - g. The young person needs to understand that multiple surgical procedures will be needed;
 - h. The young person needs to understand the long-term social effects of transition;
 - i. And so on.
749. Taking into account the effects of puberty and adolescent development, noted earlier, it is highly unlikely that anyone under the age of 18 years will be

- able to satisfy the standard set out by *Gillick*.
750. It is likely that many over the age of 18 will not understand the issues or the implications of treatment.
751. Misdiagnosis is a concern as GD has clear developmental aspects to it.
752. However, several other conditions are associated with similar behaviours, as noted in DSM-5, page 458. These include:
- a. Schizophrenia spectrum disorder;
 - b. Body dysmorphic disorder;
 - c. Transvestic disorder;
 - d. Non-gender conformity
753. And I would add: Normal gender variant behaviour.
754. As noted in the question above, 'gender development' is in part, social and as such, one cannot dismiss that early identification of GD may say more about the family dynamics than it does about the reliability of the diagnosis or the behaviour of the child.
755. Further, as noted in the evidence, child abuse is very common within the LGBTQ+ community, with the latest research indicating very high rates of poly-victimisation among gender and sexual minority groups, Sterzing et al (2019).
756. They noted that sexual victimisation ran at 80.6%, bullying at 88.8%, child 'maltreatment' at 78.8%. Interestingly, these rates were the results from participants aged 14 to 19 years.
757. However, the way in which children are treated by, and within families, is also associated with later adult behaviour. As such, those victimised through violence as children (e.g. boys) are affected in regard to their level of masculinity.
758. Further, individuals may find partners with similar behavioural traits to those 'bullying during their childhood,' and as such, may continue to be victims of the same behaviour into adulthood.
759. Extending this, might the child's gender expression at primary school be a result of factitious disorder by proxy.
760. Indeed, as many school psychologists and many schools will note, some parents are so desperate for a boy or girl that the gender of the child does

not stop the parent. Hence, girls are raised as boys and vice-versa.

761. This behaviour ceases when social services and Child and Adolescent Mental Health Services (CAMHS) are brought in together, to assist.
762. I would argue that without an appropriate assessment, the effects of such parental behaviour cannot be discounted.
763. One has to question, in this politically sensitive area, if some individuals and their choice of sexual behaviour and development, gender and otherwise, is associated at some level with their childhood experience.
764. However, this is not to dismiss gender dysphoria as a genuine area for intervention and support, where individuals struggle with their thoughts, feelings, and sense of self-identity regarding gender, but one need be open to the effects of childhood experiences as well as the normal variations and processes of adolescent development.
765. Nevertheless, given that even the GIDS Tavistock note that it is internationally recognised that “73% to 88% of children” attending a GD clinic will not continue, it raises doubt, for some, about the sources of the child's apparent symptoms.
766. One has to suggest that ‘gender dysphoria’ is somewhat more complex than simply complying with a child or families self-diagnosed opinion.
767. ‘Non-gender conformity’ may be a better term to use within childhood, rather than gender dysphoria, where it allows the child an opportunity to determine, as they mature, the nature of their gender preference and more importantly, their sexual orientation and preference. These are part of the ‘self,’ how one defines who and what we are, how we interact with others and the expectations of ourselves, others, and the world in general.
768. In childhood, gender dysphoria is vaguely associated with those who are ‘transgender,’ which is a determination that needs be made as one progresses through adolescence, where physical and hormonal changes alter our neurocognitive abilities and social emotional lives.
769. Research shows gender dysphoria is often comorbid with a variety of other conditions, such as autistic spectrum disorder, depression, and anxiety.
770. More specifically, Kaltiala-Heino et al (2018) state:
“Consolidation of identity development is a central developmental goal of adolescence, but we still do not know enough about how gender identity

and gender variance actually evolve. Treatment-seeking adolescents with GD present with considerable psychiatric comorbidity. There is little research on how GD and/or transgender identity are associated with completion of developmental tasks of adolescence," p 31.

771. That is, gender dysphoria may in part, be 'associated' with mental illness, which may in part, be associated with adolescent development. It is as one completes such a developmental phase that one may resolve many of the difficulties previously shown. Indeed, this might be consistent with the research showing that as time progresses, so children and adolescents no longer conform to the diagnosis of gender dysphoria.
772. However, to suggest that gender dysphoria is simply 'a result' of mental illness appears to be without foundation. Nevertheless, the degree of comorbidity and the developmental timing of this process (during adolescence) is unlikely to be a product of chance alone.

Are children damaged by not permitting them to 'transition,' or socially transition, at primary school age, or by not using their preferred non-birth chosen pronoun, names, etc.

773. I could find no reliable body of evidence to show children are harmed by not allowing them to transition, at any level, while in primary school. Whereas anecdotal evidence can be found, the tiny number of children identified at this age makes research problematic.
774. However, if one assumes that a child is presented to a clinic due to 'non-conformity' of whatever type, one begins with an assessment and investigation of how and why the child functions as they do. The process is the same for all young people who experience social, emotional, and mental health difficulties.
775. Indeed, for those within the school system, where their difficulties, their behaviours, are toward the extreme end of a spectrum, toward the rarest few percent of all children, the normal process is to conduct an assessment within school. That may lead to a multidisciplinary assessment guided by a legal framework, which may ultimately protect the right of the young person; a process guided by The Children and Families Act, (2014).
776. Hence, if there were identifiable difficulties with 'gender dysphoria' or non-conformity, this would be the normal starting place. It would not be to simply comply with the child and/or their parent.
777. Under any other circumstance, the more complex the problem, the more the

- local authority would engage, and would expect engagement, with and from other professionals.
778. The same processes are available to those with non-gender conformity, where that behaviour has a significant impact on daily functioning, either academic or social.
779. Within education, children are continuously assessed, and where they have difficulties, often over two-to-three years as a minimum, this may lead to a 'statutory assessment' involving multiple agencies. This, in turn, may lead to an Education, Health, and Social care plan (EHC plan), under the Children and Families Act, (2014).
780. An EHC plan is legally enforceable to protect the needs and rights of the child or adolescent.
781. In addressing educational, social, and medical needs, within the education system, one does not rely on a child and their parents. One relies on a range of professionals conducting assessments over time.
782. In school, one would consider the issue of bullying, considering the behaviour of children as part of a system. That is, both bully and victim bring to the situation part of the problem and as such, the school need address both parts/parties.
783. Within the health care system, The Child and Adolescent Mental Health Service (CAMHS), will assess and test the child; they may assess the parents, and even the entire family. They will collect collateral information from social care, from schools, and from others as needed, before offering a definitive diagnosis, of for example, Attention Deficit Hyperactivity Disorder, or its 'alternative,' an Attachment Disorder; both show the child behaving in the same way, but both have their own separate causes and treatments.
784. For children in school not requiring an EHC plan, teachers and the schools special needs coordinator (Senco) assess and intervene as required, seeking outside expertise and guidance as required; e.g. speech therapists, educational psychologists. The difficulties they address are wide ranging and their experience and expertise in supporting such children often considerable.
785. However, one must bear in mind that the difficulties with gender non-conformity are often poorly understood by parents and children, and yet the diagnosis of gender dysphoria is ultimately based on a subjective professional opinion formed via child and parent self-report; while at a pre-diagnostic stage it is often just the parent making the diagnosis.

786. Given that there is a reliable body of evidence showing that those diagnosed early in life, no longer conform to the diagnosis (GD) as they grow, develop, and mature, it indicates the risk with allowing 'early interventions,' based on the child and parent alone.
787. From this perspective, if at least half, but probably as many as 4-in-5 no longer conform to the diagnosis as they progress through childhood, puberty and adolescence, it strongly suggests that delaying any move toward transition may be in the young person's best interest.
788. It suggests that young people need time, and support.
789. One must consider, children and parents are not psychologists with qualifications and many years' experience working in different facets of developmental psychology and are rarely qualified or experienced in the changes that occur in children over the 20-to-25 years needed to reach maturity at the end of adolescence.
790. Further, one must also appreciate the LGBTQ+ community are a group who report having endured substantial abuse and mental health problems during childhood. As a result, one must consider if difficulty 'transitioning' is central to their distress, or if the cause lies elsewhere. Such considerations reinforce the view that a multidisciplinary, multiagency assessment is required prior to any move toward any form of transition.

Is there recognised psychological evidence that children expressing a desire to live in the opposite gender, given time, will alter such views?

791. Research shows, that the condition in the (vast) majority of cases resolves into what is now considered the mainstream of gender and sexual preferences.
792. That is, those diagnosed in childhood later categorise themselves as either heterosexual, homosexual or bisexual, and not with gender dysphoria.
793. Indeed, even Butler et al (2018) from the GIDS, Tavistock and Portman NHS Trust acknowledges that around 4 in every 5 children and adolescents move away from the gender dysphoric diagnosis and the need to transition.
794. The central issue is one of time and the need to allow young people to develop and mature.
795. Cognitive development needs until the mid-late teens to show the component parts of adult thought and decision making, while social

emotional development needs until the early-mid-twenties; depending upon gender.

796. However, until the brain fully matures, it is not possible to fully utilise all these component parts, with risk-taking and decision-making maturing during the early 20's.
797. Puberty and adolescence, two developmental processes, concluding at an age in the twenties, significantly alter how young people think, feel and relate to others. Until one approaches the conclusion of those processes, the outcomes are open to doubt.
798. When one looks at the treatments for GD offered to children and adolescents, even the NHS has come to acknowledge the research that there are numerous risks, both immediate and short term, as well as in the long-term.
799. Further, one must appreciate that transitioning is not about gender per se. Rather, it is a complex process involving external genitalia and issues of self, gender roles, sexual orientation (which when transitioned may be either straight or gay), and so on; these are complex issues that are not resolved in childhood.
800. One must consider, gender roles are typically laid out in the home in the first instance, and it is maturation, exposure to, and experience of alternative gender roles, that provides guidance on how young people see 'gender.' It is adolescence where this process is most pronounced in terms of its effect on gender and issues of sexual orientation and preferences; leading to a more stable concept of 'self.'
801. Sexual preference and orientation are 'two processes,' though the lines between them can be blurred.
802. Orientation refers to 'who' you are sexually; it is about who you identify with sexually, and the sexual path you choose.
803. The 'who' refers to heterosexuality, homosexuality, bisexuality, transsexual, and so on.
804. Preference refers to sexuality, what you do, and how you live your life, having chosen your orientation.
805. 'What' you do, and 'how' you live your life, are the behaviours associated with the 'who;' often referring to the 'practices' of sexuality.

806. The development of these take time and are, in the first instance, a product of puberty within the early stages of adolescent development, which is the latter and more central component; due to neurocognitive and social emotional development.
807. In essence, the determination of 'who' you are is a product of puberty, while 'what' you do and 'how' you live your life are determined by later neurocognitive and social emotional developments that follow as a result of maturation.
808. One might argue that the determination of who children become, is not completed until the individual has reached, not legal adulthood, but the completion of adolescent development, typically achieved in the early twenties for women, and mid-twenties for men. Until one nears the completion of this process, change and moving away from the process of transsexualism is a distinct probability, given that even the GIDS acknowledged up to 88% changing, with some research indicating even higher rates of change.
809. The majority of children expressing a desire to live in the opposite gender, will, given time, no longer hold such views.

What are the dangers with trans-gender affirming policies, in particular the Cornwall Guidance?

810. The problem with gender affirming policies is that they need take into account normal child and adolescent development. Those diagnosed with gender dysphoria are not abnormal and need to progress through 'normal developmental stages,' which impact long-term health, neurocognitive developments, social emotional developments and so on.
811. One sees that the policy of Cornwall shows no evidence that such processes are considered.
812. Further, such policies must also take into account the ability to children to make appropriate decisions. Indeed, this was noted in *Gillick* (1984), (1985).
813. This view, by *Gillick* is also supported by the CQC (2018) and NICE (2019).
814. Decision making need be based on intelligence, understanding, and issues of risk. The young person needs to be able to see the advantages and disadvantages from their decision and fully-understand the implications of their decisions and their actions.

815. A primary school child is not going to understand the risks associated with transitioning, the social isolation, the reaction from peers, the reaction from family and friends and so on.
816. A primary school child is not going to understand the potential long-term implications of 'off-label' medication and the harm it may do. They will not understand the immediate and short-term risks.
817. A primary school child will not understand that some of the decisions required may lead to permanent long-term harm where the effects are irreversible. According to the NHS, irreversible damage can be inflicted very quickly.
818. The idea that children can begin, and then simply change their minds, is to be naïve; it is not supported by the NHS, or research.
819. The social harm that may be done to relationships, the damage to the self, the damage within families, would all need to be considered, especially as research shows that the majority of those 'self-diagnosing,' no longer identify as transgender as they mature.
820. Society has built in safeguards to protect children, adulthood starting aged 18 years (Children Act, 1989 s105), Fraser guidelines (**1985**) regarding aspects of sexual behaviour (contraception and treatment for STD's, 2006) and *Gillick* (**1984, 1985**) in regard to decision making for medical treatment.
821. Hence, policies need to take into account such safeguards.
822. One might argue that where policies do not take into account safeguarding and child protection, then they themselves may form a risk to young people.

What are the alternative ways to assist with children suffering from gender dysphoria?

What might the Cornwall guidance have missed?

signifies an issue for the local authority

823. Gender dysphoria is an important developmental state and along with others, should be appropriately addressed by local authorities.
824. # However, in providing a policy that affects educational facilities and their students, they need to be set out from a 'child and adolescent perspective.' Such policies, at their centre, need to ensure the protection of young people.

825. One need to accept that the 'majority' state for gender and sexual behaviour is 'straight' or heterosexual, accounting for between 94% and 96% of all individuals, (ONS, **2018**).
826. The remaining groups, covering LGBTQ+, at this time, count for between 4% and 6% of the community.
827. However, as a minority group, putting it into context, if we assume 4%, and there are 7.6 billion people in the world, 300 million would be LGBTQ+.
828. # 300 million people is not a small minority, and as such, their needs should be addressed as a 'collective' by the Local Authority, where 'safeguarding' is central.
829. Making a policy for education that separates those that may be transgender fails to understand that many non-gender conforming children and adolescents will mature across the range of straight, bisexual, gay and lesbian.
830. # The term 'gender dysphoria' should not be used without an appropriate diagnosis from a medical team supported by a multiagency approach. 'Non-gender conforming' is a more accurate term especially for primary aged children. 'Gender variance' is normal.
831. Gender dysphoria as a label should follow a detailed multidisciplinary, multiagency 'developmental' assessment, led by specialists. Such assessments, as of necessity take time.
832. # An assessment should, like an EHC plan, have multiple sections from the assessments by professionals:
- a. Primary schools and secondary schools should each contribute.
 - b. Social services should contribute and a family assessment is required.
 - c. There should be a contribution from the GP, showing the evidence of need.
 - d. Therapy with child and family, as separate issues, should contribute.
 - e. A comprehensive mental health assessment is required.
833. The local authority, in protecting its children and adolescents, should encourage this multiagency approach.
834. # To aid schools and parents, the figures for the number of LGBTQ+ present within the world should be set out, to enable them to understand why this is an important area.

835. # However, allied to informing schools and parents, the figures for the developmental change that occurs need be set out. That is, 4-in-5 children as they progress into puberty and through adolescence will no longer identify as gender dysphoric. The schools and families need to understand that this figure comes from the GIDS, Tavistock and Portman NHS Trust, and is internationally recognised.
836. # Based on the research, no interventions can be allowed in primary school, until such time as there has been a full developmental assessment; which would as of necessity, take them into secondary school, giving the young person more time to mature.
837. Active interventions in primary school run counter to *Gillick*, and to current safeguarding procedures. Allowing a primary age child to engage in behaviour that may result in negative behaviour from others toward them, knowing that there is an 80% chance the child will no longer identify as GD or wishing to pursue transition in the future is unethical. The negative consequences toward the child may be considerable.
838. The local authority setting out that the assessment needs to be developmental, accepting that *Gillick (1984, 1985)*, the CQC (2018), and NICE (2019), all accept the principle that the child can only give consent when they are developmentally able, and not before.
839. # As a result of safeguarding procedures, the local authority should not support any intervention unless a multiagency assessment has taken place, and the young person has demonstrated they can fulfil the requirement of *Gillick*, for this complex area.
840. # The local authority must state with unambiguous clarity that child protection and safeguarding are primary. Further, that the use of unsafe medical approaches cannot be supported by its educational facilities, unless without such, the child's life would be in imminent danger.
841. # The local authority, working in partnership with the local NHS Trusts need to prioritise the LGBTQ+ communities to access mental health support for school aged children. The very high rates of child abuse reported by the LGBTQ+ communities, means this is an easy area for the local authority to justify.

EXPERT'S DECLARATION

I, Graham Rogers, DECLARE THAT:

1. I understand that my duty is to help the court to achieve the overriding objective by giving independent assistance by way of objective, unbiased opinion on matters within my expertise, both in preparing reports and giving oral evidence. I understand that this duty overrides any obligation to the party by whom I am engaged or the person who has paid or is liable to pay me. I confirm that I have complied with and will continue to comply with that duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
8. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if for any reason my existing report requires any correction or qualification.
11. I understand that:
 - a. my report will form the evidence to be given under oath or affirmation;
 - b. the court may at any stage direct a discussion to take place between experts;
 - c. the court may direct that, following a discussion between the experts, a statement should be prepared showing those issues which are agreed and those issues which are not agreed, together with the reasons;
 - d. I may be required to attend court to be cross-examined on my

report by a cross-examiner assisted by an expert.

- e. I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12. I have read:

- a. Part 19 of the Criminal Procedure rules
- b. Part 35 of the Civil Procedure Rules and the accompanying practice direction.

I have complied with its requirements.

13. I confirm that I have acted in accordance with the code of practice or conduct for experts of my discipline.

14. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.



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Graham Rogers

Date 21st October 2020

References

1. Aboraya A, Rankin, E, France C, El-Missiry A, and John C (2006) The Reliability of Psychiatric Diagnosis Revisited: The Clinician's Guide to Improve the Reliability of Psychiatric Diagnosis. *Psychiatry Jan*; 3(1): 41–50.
2. Aboraya (2007) Reliability of Diagnosis: Clinicians' Opinions on the Reliability of Psychiatric Diagnoses in Clinical Settings. *Psychiatry. Nov*; 4(11): 31–33
3. Amir, D, Jordan, M R., McAuliffe, K, Vallenggia, C R., Sugiyama, L S., Bribiescas, R G., Snodgrass, J. J, & Dunham, Y (2020) The developmental origins of risk and time preferences across diverse societies. *Journal of Experimental Psychology: General, Vol 149(4), Apr, 650-661*
4. Anderson, D 7. (2003). Longitudinal Study of Formal Operations in College Students. 2 pp. American Psychological Association
5. Anyanwu, F C, Akinsola, H Abayomi, T, Augustine K, & Obisie-Nmehielle, N (2020) A qualitative assessment of the influence of family dynamics on adolescents' sexual risk behaviour in a migration-affected community. *International Journal of Qualitative Studies on Health and Well-being, Vol 15(1), Dec, Article 1717322*
6. Archer R. P and Krishnamurthy R (2002) *Essentials of MMPI-A Assessment*. New York. Wiley
7. Armstrong (2019) Mental Health: 1 in 8 UK adults have suicidal thoughts due to body image. 10th Sept.
<https://www.statista.com/chart/17972/suicidal-thoughts-due-to-body-image-uk/>
8. Ash, P. (1949). The reliability of psychiatric diagnoses. *The Journal of Abnormal and Social Psychology, 44(2), 272–276.*
9. Aube J, Norcliffe H, Craig J-A and Koestner R (1995) Gender Characteristics and Adjustment-Related Outcomes: Questioning the Masculinity Model
10. Baca-Garcia E, Perez-Rodriguez M M, Basurte-Villamor I, Fernandez del Moral A L, Jimenez-Arriero M A, Gonzalez de Rivera J L, Saiz-Ruiz J and Oquendo M A (2007) Diagnostic Stability of Psychiatric in Clinical Practice. *Br J Psychiatry. Vol 190. 210 -216.*

11. Bauer, G. R., Pyne, J., Francino, M. C., & Hammond, R. (2013). Suicidality among trans people in Ontario: Implications for social work and social justice. *Service Social*, 59, 35– 62.
12. Bem S. L. (1974). "The measurement of psychological androgyny". *Journal of Consulting and Clinical Psychology*. 42 (2): 155–162.
13. Bem S. L. (1977). "On the utility of alternative procedures for assessing psychological androgyny". *Journal of Consulting and Clinical Psychology*. 45 (2): 196–205
14. Bem S. L., & Andersen, S. M. (1981). "Sex typing and androgyny in dyadic interaction: Individual differences in responsiveness to physical attractiveness." *Journal of Personality and Social Psychology*, 41, 74.
15. Bercow J (2008) *The Bercow report: a review of services for children and young people (0-19) with speech, language, and communication needs*. DCSF Publications. Annesley.
16. Bewley S, Clifford D, McCartney M and Byng R (2019) Gender incongruence in children, adolescents, and adults. *B J of Gen Practice*. Vol 69 (681) 170 - 171
17. Bos H, de Haas S, and Kuyper L (2019) Lesbian, gay, and bisexual adults: Childhood gender nonconformity, childhood trauma, and sexual victimization. *Journal of Interpersonal Violence*, Vol 34(3), Feb, 496-515
18. Branstrom R and Pachankis J E (2019) Reduction in Mental Health treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American J of Psychiatry*. Published Online: 4 Oct
19. Bullens L and van Harreveld F (2016) Second Thoughts about Decision Reversibility: An Empirical Overview. *Social and Personality Psychology Compass*, Volume10, Issue1. Pages 550-560
20. Bulter G, De Graaf N, Wren B and Carmichael P (2018) Assessment and support of children and adolescents with gender dysphoria. *Arch Dis Child*. Vol 103pp 631 – 636
21. Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin*, 56(2), 81– 105

22. Chen D, Edwards-Leeper L, Stancin T and Tishelman A (2018) Advancing the Practice of Pediatric Psychology With Transgender Youth: State of the Science, Ongoing Controversies, and Future Directions. *Clinical Practice in Pediatric Psychology*. Vol. 6, No. 1, 73–83
23. Charlton B M., Roberts A L., Rosario M, Katz-Wise S L., Calzo J P., Spiegelman D, and Austin S. B (2018) Teen pregnancy risk factors among young women of diverse sexual orientations. *Pediatrics*, Vol 141(4), Apr 1-10
24. Chorpita, B F, Weisz, J R, Daleiden, E L, Schoenwald, S K, Palinkas, L A., Miranda, J, Higa-McMillan, C K, Nakamura, B J, Austin, A. A, Borntrager, C F, Ward, A, Wells, K C, Gibbons, R D, & Research Network on Youth Mental Health Chicago IL US/ (2013) Long-term outcomes for the Child STEPs randomized effectiveness trial: A comparison of modular and standard treatment designs with usual care. *Journal of Consulting and Clinical Psychology*, Vol 81(6), Dec, 999-1009
25. Coles H, Gillett K, Murray G and Turner K (2017) The Royal College of Speech and Language Therapists: Justice Evidence Base. Consolidation: 2017. Written submission to the Ministry of Justice. <https://www.rcslt.org/-/media/Project/RCSLT/justice-evidence-base2017-1.pdf>
26. Cornwall Council (2015) Schools Transgender Guidance. The Intercom Trust on behalf of The Cornwall Transgender Guidance for Schools Partnership.
27. Criminal Procedures Rules (2020) <https://www.legislation.gov.uk/uksi/2020/759/part/19/made>
28. Cunningham, C E., Mapp, C, Rimas, H, Cunningham, L, Mielko, S, Vaillancourt, T, & Marcus, M (2016) What limits the effectiveness of antibullying programs? A thematic analysis of the perspective of students. *Psychology of Violence*, Vol 6(4), Oct 596-606
29. Daley T, Frossoehme D, McGuire J K, Corathers S, Conrad L A and Lipstein E A (2019) "I couldn't see a downside." Decision-making about gender affirming hormone therapy. *Journal of Adolescent Health*, Vol 65(2), Aug, 274-279
30. Daniolos P T, Telingator C J. (2013) Engendering identity. *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol 52(12), Dec 1245-1247
31. David, J G, Lo M S, and Langer D A (2018) Adolescent and Parent

Perspectives on Medical Decision-Making for Chronic Illness. *Families, Systems, & Health*, Vol. 36, No. 2, 248–251

32. Defoe, I N., Dubas, J S, Dalmaijer, E S., & van Aken, M A. G. (2020) Is the peer presence effect on heightened adolescent risky decision-making only present in males? *Journal of Youth and Adolescence*, Vol 49(3), Mar, 693-705

33. deRoos-Cassini, Terri A., de St. Aubin, Ed, Valvano, Abbey K., Hastings, James, & Brasel, Karen J. (2013) Meaning-making appraisals relevant to adjustment for veterans with spinal cord injury. *Psychological Services*, Vol 10(2), May, 186-193

34. Dhejne C, Lichtenstein P, Boman M, Johansson A L, Langstrom N and Landen M (2011) Long-term follow-up transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE*, Vol 6(2) Feb 22, Article e16885

35. Drummond K. D. Bradley S. J. Badali-Peterson M and Zucker K. J (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45.

36. Duell, N, Steinberg, L, Icenogle, G, Chein, J, Chaudhary, N, Di Giunta, L, Dodge, K A., Fantl, K A., Lansford, J E., Oburu, P, Pastorelli, C, Skinner, A T., Sorbring, E, Tapanya, S, Uribe T, L M, Alampay, L P, Al-Hassan, S M., Takash, H M. S., Bacchini, D, & Chang, L (2018) Age patterns in risk taking across the world. *Journal of Youth and Adolescence*, Vol 47(5), May, 1052-1072

37. Dutton, E, Madison, G (2020) Gender dysphoria and transgender identity is associated with physiological and psychological masculinization: A theoretical integration of findings, supported by systematic reviews. *Sexuality Research & Social Policy: A Journal of the NSRC*, Aug 13 , No Pagination Specified

38. Fisk N. M. (1974) Gender Dysphoria Syndrome—the conceptualization that liberalizes indication for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine*.120(5):386–391.

39. Fivecoat H C, Cos T A and Possemato K. (2017) Special Ethical Considerations for Behavioural Health Consultants in the Primary Care Setting. *Professional Psychology: Research and Practice In the public domain*. Vol. 48, No. 5, 335–342

40. Fontanari A M V, Rovaris D L, Costa A B, Pasley A, Cupertino R B, Soll B

M B Schwarz K, Silva, D C, Borba, A O, Mueller A, Bau, C H D, & Lobato M I R (2018) Childhood maltreatment linked with a deterioration of psychosocial outcomes in adult life for southern Brazilian transgender women. *Journal of Immigrant and Minority Health*, Vol 20(1), Feb, 33-43

41. Forde C, and Duvvury N (2017) Sexual violence, masculinity, and the journey of recovery. *Psychology of Men & Masculinity*, Vol 18(4), Oct 301-310

42. Gaither T W, Awad M A, Osterberg E C, Murphy G P, Romero A, Bowers M L, Breyer B N. (2018) Post-operative complications following Primary Penile Inversion Vaginoplasty among 330 Male-to-Female Transgender Patients. *J Urol*. Mar. Vol 199(3):760-765.

43. Geary, D C., Bjorklund, D F. (2000) Evolutionary developmental psychology. *Child Development*, Vol 71(1), Jan-Feb, 57-65

44. Genovese, J. E. C. (2003). Piaget, pedagogy, and evolutionary psychology. *Evolutionary Psychology*, 1, 127–137.

45. Gardner M and Steinberg L (2005) Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. *Developmental Psychology* Vol. 41, No. 4, 625–635

46. Getahun D1, Nash R, Flanders WD, Baird TC, Becerra-Culqui TA, Cromwell L, Hunkeler E, Lash TL, Millman A, Quinn VP, Robinson B, Roblin D, Silverberg MJ, Safer J, Slovis J, Tangpricha V, Goodman M. (2018) Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21;169(4):205-213. doi: 10.7326/M17-2785. Epub Jul 10.

47. *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1984] Q.B. 581. As cited in *Children's Legal Centre* (1985) Landmark decision for children's rights. *Childright*, 22: 11-18.

48. *Gillick v West Norfolk & Wisbech Area Health Authority*, UKHL 7 (17 October 1985) Available via (BAIIII) in *The Law Reports (Appeal Cases)* [1986] AC 112 <http://www.bailii.org/uk/cases/UKHL/1985/7.htm>

49. *Gillick v West Norfolk and Wisbech AHA* AC 112 ((HL)) 1986

50. Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender

Equality and National Gay and Lesbian Task Force.

51. Griffith R (2016) What is Gillick Competence? *Hum Vaccin Immunother.* Jan; 12(1): 244–247.
52. Hackenberg A J (2010) Students' Reasoning With Reversible Multiplicative Relationships *Cognition and Instruction* Volume 28, - Issue 4 Pages 383-432
53. Harlow C W (1999) Prior Abuse reported by Inmates and Probationers. Bureau of Justice Statistics: Selected Findings. US Department of Justice. Office of Justice Programs. NCJ 172879
54. Hasan M M, Abu-Hassan K, Lwin K and Hossain M A (2016) Reversible decision support system: Minimising cognitive dissonance in multi-criteria based complex system using fuzzy analytic hierarchy process. 2016 8th Computer Science and Electronic Engineering (CEECE). DOI: 10.1109/CEECE.2016.7835915
55. Heller A S, Cohen A O, Dreyfus M F W and Casey B J (2016) Changes in cortico-subcortical and subcortico-subcortical connectivity impact cognitive control to emotional cues across development. *Social Cognitive and Affective Neuroscience*, Vol 11(12), Dec, 1910-1918
56. Hopwood, C J. and Bornstein, R F. (2014) *Multimethod Clinical Assessment*. Guilford Press. NY
57. Icenogle G, Steinberg L, Duell N, Chein J, Chang L, Nandita D, Giunta L, Dodge K A, Fanti K A, Lansford J E, Oburu P, Pastorelli C, Skinner A T, Serrano E, Tapanya S, Uribe T, Lilana M, Alampay L P, Al-Hassan S M, Takash H M S and Bacchini D (2019) Adolescent' cognitive capacity reaches adult levels prior to their psychosocial maturity: Evidence for a "maturity gap" in a multinational, cross sectional sample. *Law and Human Behavior*, Vol 43(1), Feb, 69-85
58. Ikram M, Purwanto , Parta I N And Susanto H (2020) Exploring the Potential Role of Reversible Reasoning: Cognitive Research on Inverse Function Problems in Mathematics. *Journal for the Education of Gifted Young Scientists*, 8(1), 591-611,
59. Inhelder, B., & Piaget, J. (1958). *The growth of logical thinking from childhood to adolescence: An essay on the construction of formal operational structures*. New York: Basic Books
60. Ives G C, Fein L a, Finch L, Sluiter E C, Lane M, Kuzon W M and Salgado (2019) Evaluation of BMI as a Risk Factor for Complications following Gender-

affirming Penile Inversion Vaginoplasty. *Plast Reconstr Surg Glob Open* Mar Vol 13. 7 (3):e2097

61. Jantz G L (2014) Brain differences between genders: Do you ever wonder why men and women think so differently? *Psychology Today*. Feb 27th

62. Johansson, A, Huhtamäki, A, Sainio, M, Kaljonen, A, Boivin, M, & Salmivalli, C (2020) Heritability of bullying and victimization in children and adolescents: Moderation by the kiva antibullying program. *Journal of Clinical Child and Adolescent Psychology*, Mar 17, No Pagination Specified

63. Juster R-P, Pruessner J, Desrochers A, Bourdon O, Durand N, Wan N, Tourjman V, Kouassi E, Lesage A, & Lupien, S. (2016) Sex and gender roles in relation to mental health and allostatic load. *Psychosomatic Medicine*. 78(7):788–804,

64. Kaltiala-Heino K H, Bergman H, Työlajärvi M and Frisén L (2018) Gender dysphoria in adolescence: current perspectives. *Adolescent Health, Medicine and Therapeutics*. Open Access.

65. Kankaraš, M. (2017), "Personality matters: Relevance and assessment of personality characteristics", OECD Education Working Papers, No. 157, OECD Publishing, Paris. <http://dx.doi.org/10.1787/8a294376-en>

66. Kennedy I and Grubb A. (1998) *Principles of Medical Law* Oxford: OUP

67. Knudson G., de Cuypere G., Bockting W. (2010) Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of the world professional association for transgender health. *International Journal of Transgenderism*. 12(2):115–118.

68. Kon A A (2014) Transgender Children and Adolescents. *The American Journal of Bioethics*. Vol 14. 48 – 50. DOI: 10.1080/15265161.2014.862410

69. Kull, R M., Greytak, E A., Kosciw, J G., & Villenas, C (2016) Effectiveness of school district antibullying policies in improving LGBT youths' school climate. *Psychology of Sexual Orientation and Gender Diversity*, Vol 3(4), Dec, 407-415

70. Lampl M, Gotsch F, Kusanovic J P et al (2010) Sex differences in fetal growth responses to maternal height and weight. *Am. J. Hum. Biol.* 22 (4). 431-443

71. Lichtenberger E. O and Kaufman A (2009) *Essentials of WAIS IV Assessment*. Hoboken. Wiley.

72. Lim M, Lee S and Park J (2014) Difference in suicide methods used between suicide attempters and suicide completers. *International J of Mental Health Systems*. vol 8, 54
73. Massie J P, Morrison S D, Van Maasdam J and Satterhite T (2018) Predictors of Patient Satisfaction and Postoperative Complications in Penile Inversion Vaginoplasty. *Plast Reconstr Surg*. Jun Vol 141 (6):911e-921e.
74. Martinez, J. E., Mack, M. L., Bauer, J.-R., Roe, M. A., & Church, J. A. (2018). Perceptual Biases during Cued Task Switching Relate to Decision Process Differences Between Children and Adults. *Journal of Experimental Psychology: Human Perception and Performance*. Vol 44(10), Oct, 1603-1618
75. McDaniel, J. S., Purcell, D., & D'Augelli, A. R. (2001). The relationship between sexual orientation and risk for suicide: Research findings and future directions for research and prevention. *Suicide and Life Threatening Behavior*, 31, 84–105.
76. McKenzie S K, Collings S, Jenkin G, and River J (2018), Masculinity, Social Connectedness, and Mental Health: Men's Diverse Patterns of Practice. *Am J Mens Health*. Sep; 12(5): 1247–1261.
77. McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans Mental Health and Emotional Wellbeing Study 2012*. Retrieved from Scottish Transgender Alliance
78. Meehl P (1954) Clinical versus statistical prediction: A theoretical analysis and a review of the evidence. University of Minnesota Press. <https://doi.org/10.1037/11281-000>
79. Mental Health Foundation (2019). *Mental Health Statistics: Suicide*. 11th Sept. <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-suicide>
80. Meyer G. J. Finn S. E. Eyde L. D. Kay G. G. Moreland K. L. Dies R. R. Eisman E/ J. Kubiszyn T. W and Reed G. M (2001). *Psychological Testing and Psychological Assessment: A Review of Evidence and Issues*. American Psychological Association, Vol. 56, No. 2, 128-165
81. Monstrey S J, P Ceulemans, and Hoebeke P (2011) Aesthetic and Functional Genital and Perineal Surgery: Male Sex Reassignment Surgery in the Female-to-Male Transsexual. *Semin Plast Surg*. Aug; 25(3): 229–244. doi: 10.1055/s-0031-1281493

82. Moody C, Nate F, Pelaez S and Smith N g (2015). "Without this, I would for sure already be dead." A qualitative inquiry regarding suicide protective factors among trans adults. *Psychology of Sexual Orientation and Gender Diversity*, Vol 2(3), Sept 266-280
83. Nagel A G, Guarnera L and Reppicci N D (2016) Adolescent development, mental disorder, and decision making in delinquent youth. In: Heilbrun, Kirk (Ed); DeMatteo, David (Ed) & Goldstein, Naomi E. S. (Ed). *APA handbook of psychology and juvenile justice.*, (pp. 117-138).
84. Nobili, A, Glazebrook, C, Bouman, W P, Baron-Cohen, S, & Arcelus, J (2020) The stability of autistic traits in transgender adults following cross-sex hormone treatment. *International Journal of Transgender Health*, Jun 30, No Pagination Specified
85. Nocentini, A, Menesini, E, & Pluess, M (2018) The personality trait of environmental sensitivity predicts children's positive response to school-based antibullying intervention. *Clinical Psychological Science*, Vol 6(6), Nov, 848-859
86. ONS. (2016) *Sexual Identity*, UK.
<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016>
87. ONS (2016b) *Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016*
88. ONS(2016)
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuseduringchildhood/findingsfromtheyearendingmarch2016crimesurveyforenglandandwales>
89. ONS(2018)
<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018>
90. ONS. (2019). *Suicides in the UK: 2018 registrations*. Retrieved from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations>
91. Patel H, Arruarana V, Yao L, Cui X, Ray E,. (2020) Effects of hormones and hormone therapy on breast tissue in transgender patients: a concise review. *Endocrine*. Feb 17. doi: 10.1007/s12020-020-02197-5. [Epub ahead of print]

92. Pecora, L A., Hooley, M, Sperry, L, Mesibov, G B., & Stokes, M A. (2020) Sexuality and gender issues in individuals with autism spectrum disorder. *Child and Adolescent Psychiatric Clinics of North America*, Vol 29(3), Jul 543-556
93. Penner F, Gambin M, and Sharp C (2019) Childhood maltreatment and identity diffusion among inpatient adolescents: The role of reflective function. *Journal of Adolescence*, Vol 76, Oct, 65-74
94. Piegza M, Leksowska A, Pudlo R, Badura-Brzoza K, Matysiakiewicz J, Gierlotka Z, and Gorczyca P W. (2014) Zaburzenia identyfikacji płciowej czy zachowania andromimetyczne u ofiary kazirodztwa—Studium przypadku. / Gender identity disorders or andromimetic behaviour in a victim of incest—A case study. *Psychiatria Polska*, Vol 48(1), 135-144
95. Ross, C A. (2015) Commentary: Problems with the sexual disorders sections of DSM-5. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, Vol 24(2), Feb, 195-201.
96. Saketopoulou, A (2014) Mourning the body as bedrock: Developmental considerations in treating transsexual patients analytically. *Journal of the American Psychoanalytic Association*, Vol 62(5), Oct 773-806
97. Samaritans.org (2019) Suicide facts and figures. <https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/>
98. Sawyer S M, Azzopardi P S, Wickremarathne M D S and Patton G C (2018) The Age of Adolescence. *The Lancet: Child and Adolescent Health*. Vol 2. 223 - 228
99. Scanlon, K., Travers, R., Coleman, T., Bauer, G., & Boyce, M. (2010). Ontario's trans communities and suicide: Transphobia is bad for our health. *Trans Pulse E-Bulletin*, 1
100. Schmidt, H O., Fonda, C P. (1956) The reliability of psychiatric diagnosis: a new look. *The Journal of Abnormal and Social Psychology*, Vol 52(2), Mar, 262-267.
101. Schweizer, Tina H., Snyder, Hannah R., Young, Jami F., & Hankin, Benjamin L. The breadth and potency of transdiagnostic cognitive risks for psychopathology in youth. *Journal of Consulting and Clinical Psychology*, Vol 88(3), Mar 2020, 196-211),
102. Shulman, E P., Smith, A R., Silva, K, Icenogle, G, Duell, N, Chein, J, &

Steinberg, L (2016) The dual systems model: Review, reappraisal, and reaffirmation. *Developmental Cognitive Neuroscience*, Vol 17, Feb, 103-117

103. Sparrow N (2018) Nigel's surgery 8: Gillick competency and Fraser guidelines.

<https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines>

104. Steensma T. D. McGuire J. K. Kreukels B. P. C. Beekman A. J. and Cohen-Kettenis P. T (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590.

105. Steensma, T D., van der Ende, J, Verhulst, F C., & Cohen-Kettenis, P T. (2013b) Gender variance in childhood and sexual orientation in adulthood: A prospective study. *Journal of Sexual Medicine*, Vol 10(11), Nov, 2723-2733

106. Steinberg, L, Icenogle, G, Shulman, E P., Breiner, K, Chein, J, Bacchini, D, Chang, L, Chaudhary, Nandita, Di Giunta, L, Dodge, K A., Fanti, K A., Lansford, J E., Malone, P S., Oburu, P Pastorelli, C, Skinner, A T., Sorbring, E Tapanya, S, Tirado, L M , Alampay, L P, Al-Hassan, S M., & Takash, H M. S. (2018) Around the world, adolescence is a time of heightened sensation seeking and immature self-regulation. *Developmental Science*, Vol 21(2), Mar, 1-13

107. Stepp, Stephanie D., Olino, Thomas M., Klein, Daniel N., Seeley, John R., & Lewinsohn, Peter M. (2013) Unique influences of adolescent antecedents on adult borderline personality disorder features. *Personality Disorders: Theory, Research, and Treatment*, Vol 4(3), Jul, 223-229

108. Sterzing, P R., Gartner, R E., Goldbach, J T., McGeough, B L., Ratliff, G. A, & Johnson, K C. (2019). Polyvictimization prevalence rates for sexual and gender minority adolescents: Breaking down the silos of victimization research. *Psychology of Violence*, Vol 9(4), Jul, 419-430

109. Stonewall (2019) Trans Key Stats

https://www.stonewall.org.uk/sites/default/files/trans_stats.pdf

110. Tully G (2019) Tackling risks to quality of forensic science in the CJS. Bond Solon Expert Witness Conference. 8th November.

111. van de Griff T C, Elaut E, Cerwenka S C, Cohen-Kettenis P T, and Kreukels B P C (2018) Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study. *J Sex Marital Ther.* Feb 17; 44(2):138-148. doi: 10.1080/0092623X.2017.1326190.

112. Vander Stoep A, McCauley E, Flynn C and Stone A (2009) Thoughts of Death and Suicide in Early Adolescence. *Suicide Life Threat Behav.* 39 (6) 599 doi:10.1521/suli.2009.39.6.599
113. Verseveld, M D. A., Fekkink, R G., Fekkes, M, & Oostdam, R J. (2019) Effects of antibullying programs on teachers' interventions in bullying situations. A meta-analysis. *Psychology in the Schools*, Aug 8 , No Pagination Specified
114. Wallien M S C, Swaab H and Cohen-Kettenis P T (2007) Psychiatric co-morbidity among clinically referred children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* : 46, 74-91
115. Wallien M. S. C and Cohen-Kettenis P. T (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 1413–1423.
116. Wechsler D (2008) WAIS IV: Technical manual. San Antonio, TX. The Psychological Corporation.
117. Weiss L G, Saklofske D. H, Coalson D. L and Engi Raiford S. (2010) WAIS IV Clinical Use and Interpretation. London. AP.
118. Wheeler R. (2006) Gillick or Fraser? A plea for consistency over competence in children. *British Medical J*; 332(7545):807
119. Wheelock M D, Hect J L, Hernandez-Andrade E et al (2019) Sex Differences in Functional Connectivity during fetal brain development. *Developmental Cognitive Neuroscience*. 36. 1 - 10
120. Wright A J (2011) *Conducting Psychological Assessment*. John Wiley and Sons. Hoboken
121. World Health Organisation (2019) <https://www.who.int/gender-equity-rights/understanding/gender-definition/en/>
122. World Health Organisation (2020) <http://www.euro.who.int/en/health-topics/Health-systems/patient-safety/data-and-statistics>
123. WPATH. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7th. WPATH; 2012. Coleman, E and Bockting, W and Botzer, M and Cohen-Kettenis, P and DeCuypere, G and Feldman, J and Fraser, L and Green, J and Knudson, G and Meyer, WJ and

Monstrey, S and Adler, RK and Brown, GR and Devor, AH and Ehrbar, R and Ettner, R and Eyer, E and Garofalo, R and Karasic, DH and Lev, AI and Mayer, G and Meyer-Bahlburg, H and Hall, BP and Pfäfflin, F and Rachlin, K and Robinson, B and Schechter, LS and Tangpricha, V and van Trotsenburg, M and Vitale, A and Winter, S and Whittle, ST and Wylie, KR and Zucker, K.

Diagnosis

ICD-11 (WHO, 2018) recognises 'gender incongruence' and 'gender incongruence of childhood.'

ICD-11

Adolescence and adulthood:

"Gender Incongruence of Adolescence and Adulthood is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

Childhood:

"Gender incongruence of childhood is characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

Comment

In childhood, talking about "anticipated secondary sex characteristics" when one does not have any experience of such, indicates concern over those who produced this definition/diagnosis.

Until one has progressed into and through puberty and adolescence, the outcome is unclear regarding gender incongruence.

Diagnosis of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults.

In adolescents and adults gender dysphoria diagnosis involves a difference

between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months.

1. A strong desire to be of the other gender or an insistence that one is the other gender
2. A strong preference for wearing clothes typical of the opposite gender
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. A strong rejection of toys, games and activities typical of one's assigned gender
7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender

For children, cross-gender behaviors may start between ages 2 and 4, the same age at which most typically developing children begin showing gendered behaviors and interests. Gender atypical behavior is common among young children and may be part of normal development. Children who meet the criteria for gender dysphoria may or may not continue to experience it into adolescence and adulthood. Some research shows that children who had more intense symptoms and distress, who were more persistent, insistent and consistent in their cross-gender statements and behaviors, and who used more declarative statements ("I am a boy (or girl)" rather than "I want to be a boy (or girl)") were more likely to become transgender adults.

3, 4

The above, Cut and paste from:

<https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

Comment

There is acknowledgement that "gender atypical behaviour" is common among young children and may be part of normal development.

There is acknowledgement that "children who meet the criteria for gender dysphoria may or may not continue to experience it into adolescence and adulthood." However, it raises the possibility that perhaps for children, an alternative diagnostic label is required.

NHS: Gender Dysphoria Treatment

<https://www.nhs.uk/conditions/gender-dysphoria/treatment/>

Downloaded, 22nd July 2020; Cut and Paste

Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.

Although the Gender Identity Development Service (GIDS) advises this is a physically reversible treatment if stopped, it is not known what the psychological effects may be.

It's also not known whether hormone blockers affect the development of the teenage brain or children's bones. Side effects may also include hot flushes, fatigue and mood alterations.

From the age of 16, teenagers who've been on hormone blockers for at least 12 months may be given cross-sex hormones, also known as gender-affirming hormones.

These hormones cause some irreversible changes, such as:

Breast development (caused by taking oestrogen)

Breaking or deepening of the voice (caused by taking testosterone)

Long-term cross-sex hormone treatment may cause temporary or even permanent infertility.

However, as cross-sex hormones affect people differently, they should not be considered a reliable form of contraception.

There is some uncertainty about the risks of long-term cross-sex hormone treatment.

The NHS in England is currently reviewing the evidence on the use of cross-sex hormones by the Gender Identity Development Service.

World Health Organisation

https://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/

The following has been 'cut-and-paste.'

Adolescent development

Key points

- Adolescence is one of the most rapid phases of human development.
- Biological maturity precedes psychosocial maturity. This has implications for policy and programme responses to the exploration and experimentation that takes place during adolescence.
- The characteristics of both the individual and the environment influence the changes taking place during adolescence.
- Younger adolescents may be particularly vulnerable when their capacities are still developing and they are beginning to move outside the confines of their families.
- The changes in adolescence have health consequence not only in adolescence but also over the life-course.
- The unique nature and importance of adolescence mandates explicit and specific attention in health policy and programmes.

Recognizing adolescence

Adolescence is a period of life with specific health and developmental needs and rights. It is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire attributes and abilities that will be important for enjoying the adolescent years and assuming adult roles.

All societies recognize that there is a difference between being a child and becoming an adult. How this transition from childhood to adulthood is defined and recognized differs between cultures and over time. In the past it has often been relatively rapid, and in some societies it still is. In many countries, however, this is changing.

The period between childhood and adulthood is growing longer and more distinct. Puberty is starting earlier in many countries, although in general the timing of menarche has levelled off in high income countries at 12–13 years. At the same

time, key social transitions to adulthood are postponed until well after biological maturity. Young people spend more years in education and training, their expectations have changed, and contraception is increasingly available to prevent pregnancy. As a result, young people take on adult roles and responsibilities later, such as family formation and employment.

How people understand what is taking place during adolescence and how they think and talk about adolescents, as problems or as social capital, for example, is important for what they do and how they do it. This section, therefore, outlines the characteristics of adolescence and explains why adolescence is a special period requiring explicit attention in policies and programmes.

Defining terms: The World Health Organization (WHO) defines adolescents as those people between 10 and 19 years of age. The great majority of adolescents are, therefore, included in the age-based definition of “child”, adopted by the Convention on the Rights of the Child, as a person under the age of 18 years. Other overlapping terms used in this report are youth (defined by the United Nations as 15–24 years) and young people (10–24 years), a term used by WHO and others to combine adolescents and youth.

While these terms are sometimes used interchangeably and may be defined differently in different countries, with “adolescence”, for example, starting at 12 years or “youth” continuing into the mid-30s, this report focuses primarily on the second decade of life. When data on youth or young people are included, this is usually because available data have been aggregated in ways that do not distinguish the adolescent years specifically.

Age: not the whole story

Age is a convenient way to define adolescence. But it is only one characteristic that delineates this period of development. Age is often more appropriate for assessing and comparing biological changes (e.g. puberty), which are fairly universal, than the social transitions, which vary more with the socio-cultural environment.

The biological changes during adolescence do not all start at 10 years or stop at 20 years. Some important endocrine changes start before age 10—for example, the production of adrenal androgens—and some neurodevelopmental changes that take place during adolescence continue into the early twenties. Still, in general the most profound and rapid pubertal changes take place during the second decade.

Of course, a 10-year-old is very different from a 19-year-old. To accommodate the different phases of development in the second decade of life, adolescence is often divided into early (10–13 years), middle (14–16 years) and late (17–19 years) adolescence.

In addition to age, other important variables are sex—adolescent girls tend to reach biologically defined developmental milestones up to two years ahead of adolescent boys—and gender, since expectations and societal norms differ significantly between adolescent boys and adolescent girls in most societies.

Adolescence: physical changes

Adolescence is one of the most rapid phases of human development. Although the order of many of the changes appears to be universal, their timing and the speed of change vary among and even within individuals. Both the characteristics of an individual (e.g. sex) and external factors (e.g. inadequate nutrition, an abusive environment) influence these changes.

Many biological changes take place during the adolescent years. Most obvious are the physical changes, for example, increases in height, acquisition of muscle mass, the distribution of body fat and the development of secondary sexual characteristics.

Underlying these physical changes is a wide spectrum of endocrine changes (gonadarche and adrenarche), including hormones that affect gonadal maturation and the production of gonadal sex steroids. The growth spurt during early and mid-adolescence is regulated by the complex, inter-related production of a number of hormones. It takes place later and over a longer period in boys than girls. Hormonal changes, such as the regulation of oxytocin and vasopressin, also may affect how adolescents interact with others.

Internal and external influences at work:

All of these biological changes can be affected by factors internal to the adolescent, such as chronic illness and under-nutrition, and by external factors, such as stress within the family.

Similar factors may affect girls and boys differently. For example, high body mass index (BMI) may be associated with earlier puberty in girls but delayed puberty in boys. Similarly, early puberty may affect obesity in adolescent girls and boys differently

Adolescence: neurodevelopmental changes

Important neuronal developments are also taking place during the adolescent years. These developments are linked to hormonal changes but are not always dependent on them. Developments are taking place in regions of the brain, such as the limbic system, that are responsible for pleasure seeking and reward processing, emotional responses and sleep regulation. At the same time, changes are taking

place in the pre-frontal cortex, the area responsible for what are called executive functions: decision-making, organization, impulse control and planning for the future. The changes in the pre-frontal cortex occur later in adolescence than the limbic system changes.

This is not to suggest that young adolescents are incapable of decision-making or planning for their futures. In fact, some of the changes in social and emotional processing that take place during adolescence may increase adolescents' ability to adjust to changing social contexts.

However, neurodevelopment does have implications for the exploration and experimentation that takes place during adolescence, because biological maturity precedes psychosocial maturity and, to some extent, there is disconnect between adolescents' physical capacities, their sensation seeking and their capacity for self-control. This disconnect underlies some of the risk-behaviours and subsequent health problems outlined in Sections 3 and 4 of this report. Of course, most adolescents are able to explore and experiment in ways that contribute to their development and do not take up behaviours that undermine their health.

We now know that the adolescent brain has significant neural plasticity, that is, it is still able to change. This means that there is the potential in adolescence to ameliorate the impact of negative experiences earlier in life, for example, child abuse, and to promote positive developments that will enhance intellectual ability and emotional functioning.

Adolescence: psychological and social changes

Psychosocial changes: Linked to the hormonal and neurodevelopmental changes that are taking place are psychosocial and emotional changes and increasing cognitive and intellectual capacities. Over the course of the second decade, adolescents develop stronger reasoning skills, logical and moral thinking, and become more capable of abstract thinking and making rational judgements. Also, they are more able to take other people's perspectives into consideration and often want to do something about the social issues that they encounter in their lives.

At the same time, adolescents are developing and consolidating their sense of self. With this increasing self-identity, including their development of sexual identity, comes growing concern about other people's opinions, particularly those of their peers.

Also, adolescents want greater independence and responsibility. They increasingly want to assert more autonomy over their decisions, emotions and actions and to disengage from parental control. Their social and cultural environment importantly affects how adolescents express this desire for autonomy.

Younger adolescents may be particularly vulnerable when their capacities are still developing and at the same time they begin to move outside the confines of their families and start taking independent decisions—ranging from who they spend time with to what food they eat

Changes in the external environment: Changes taking place in the adolescent's environment both affect and are affected by the internal changes of adolescence. These external influences, which differ among cultures and societies, include social values and norms and the changing roles, responsibilities, relationships and expectations of this period of life (see Section 5). These changes affect adolescents in their immediate environment of family, school and community but reflect a range of wider societal changes, including increasing urbanization, globalization and access to digital media and social networks.

While adolescents experience similar biological, cognitive and psychosocial developmental processes, the timing and influence of these processes depend on both individual characteristics and the environments in which they live, learn, play and work.

Implications for health and behaviour

In many ways adolescent development drives the changes in the disease burden between childhood to adulthood—for example, the increase with age in sexual and reproductive health problems, mental illness and injuries.

Adolescents' neurodevelopmental changes and evolving capacities affect how they perceive risk, how they act on communication about risky behaviours, how they think about the present and the future, and what influences their ideas and actions.

The changes during puberty affect the incidence and clinical manifestations of a number of diseases. These include polycystic ovarian syndrome, eating disorders, depression, epilepsy, type 1 diabetes and other autoimmune diseases. At the same time, while the changes during puberty may have an impact on chronic illnesses, chronic conditions in turn influence adolescent development. Furthermore, the developmental processes taking place affect both the causes and the responses to disability during the adolescent years.

In addition, the social and emotional changes during adolescence heighten risks for behavioural problems such as substance abuse, self-harm and socially disruptive behaviours. For example, early onset of puberty has been linked to subsequent emotional and behavioural problems in adolescent girls and boys.

The appearance of certain health problems in adolescence, including substance use disorders, mental disorders and injuries, likely reflects both the biological changes of puberty and the social context in which young people are growing up. Other conditions, such as the increased incidence of certain infectious diseases, for example, schistosomiasis, may simply result from the daily activities of adolescents during this period of their lives.

Many of the health-related behaviours that arise during adolescence have implications for both present and future health and development. For example, alcohol use and obesity in early adolescence not only compromise adolescent development, but they also predict health-compromising alcohol use and obesity in later life,^{34 35} with serious implications for public health

It is perhaps not surprising that nearly 100% of the respondents to the WHO global community consultation with adolescents felt that their health was an important issue. However, what is interesting about the responses is that over one-quarter emphasized that their health now was important for their future ability to develop their full potential and because it has implications for their health in adulthood.

Implications for policies and programmes

The changes that take place during adolescence suggest nine observations with implications for health policies and programmes:

Adolescents need explicit attention.

Adolescents are not simply big children or small adults. Unique developmental processes take place during this period. Adolescents have specific characteristics that need to be taken into consideration in policies and programmes and in the strategies to reach this section of the population with health promotion, prevention, treatment and care.

Adolescents are not all the same.

During adolescence the components of physical and psychosocial development take place at different speeds and duration, even if the sequence is universal. Policies and programmes need to take into consideration the heterogeneity of adolescents, including the differing developmental phases and abilities of younger and older adolescents and of adolescent girls and boys.

Some adolescents are particularly vulnerable.

The environments in which some adolescents live, learn and grow can undermine their physical, psychosocial and emotional development—for example, where

adolescents lack parental guidance and support, face food shortages, or are surrounded by violence, exploitation and abuse. Policies and programmes need to specifically and explicitly address these adolescents to protect, respect and fulfil their rights to the highest attainable standard of health.

Adolescent development has implications for adolescent health

Developmental changes during adolescence have broad implications for health and disease and for the initiation of health-related behaviours during adolescence. Prevention efforts need to direct interventions to factors that negatively affect development and increase health-compromising behaviours. Service delivery programmes and providers need the awareness and skills to diagnose and respond to health problems related to the developmental changes taking place.

Adolescent development has health implications throughout life.

Adolescence provides opportunities to make up, both physically and mentally, for developmental deficits in the first decade of life. At the same time, health interventions are needed in adolescence to build on the investments made during the first decade, in order to maintain positive momentum for transitions to adulthood and health throughout life.

The changes during adolescence affect how adolescents think and act.

Recent findings about neurodevelopment have implications for policies and programmes in a range of sectors. For example, understanding the impact of emotionally charged situations on adolescent behaviour (so-called “hot cognition”) supports policies for graduated driving licenses.

Realizing that adolescents are more motivated by reward than punishment calls into question correctional approaches to deviant behaviour during adolescence. Appreciating that adolescents are more focused on the present than the future has implications for health education messages. The fact that adolescent brains are in some ways designed to encourage risk-taking supports efforts to reduce the harm associated with health-compromising behaviours rather than simply trying to prevent all risk-taking—use of condoms is a good example. And the changes taking place in the circadian rhythm of adolescents has implications for school start times.

Adolescents need to understand the processes taking place during adolescence.

Adolescents may have concerns about the normal developmental processes that are taking place, ranging from the physical manifestations of menarche and spermarche to volatile feelings and emotions. The health sector can be an important source of correct information and offer opportunities for adolescents to

discuss their concerns with trained service providers or peers, through health facilities or in other settings such as schools.

To contribute positively, adults need to understand the processes taking place during adolescence.

How adolescents are supported during this period of rapid development determines whether they can take advantage of the opportunities and avoid the threats that are inherent in this period of first-time experiences. To provide the support that is needed, the significant adults in their lives, including parents, teachers, service providers and other duty-bearers, need to understand the changes taking place during the adolescent years.

Public health and human rights converge around concepts of adolescent development.

There are important parallels between current scientific understanding of the changes during adolescence and a range of human rights principles, including evolving capacities and best interests of the child. These principles can guide health-sector decisions on issues of importance to adolescent health, for example, prevention interventions (e.g. harm reduction) and the provision of services (e.g. informed consent by mature minors). A human rights-based approach also helps support good practices in public health, for example, non-discrimination, ensuring the participation of adolescents (Article 12)³⁶ and promoting intersectoral collaboration (i.e. the indivisibility of human rights).

WHO, (2020)

The WHO cite 518 'references' used to support their position above.

<https://apps.who.int/adolescent/second-decade/reference.html#section2>

A step back: child development

The following is a very brief summary of significant developmental issues

The WHO does not provide a commentary such as the above for 'childhood.'

However, it cites 'child development' in terms of 0 – 8 years during which a child makes rapid physical and developmental growth, heavily influenced by parenting, its social world, and environmental factors.

Nevertheless, the WHO has a flexible approach to its definitions, allowing childhood, to span 0 to 9 years; as shown with 'adolescence' above.

WHO: In general terms, childhood is a period of continuous growth and

development, most readily split between early childhood (0 - 4 years) and middle childhood (5 - 8 years); the latter stage being one of greater independence and interacting with the social world.

However, what one notices with the WHO approach is a flexible space/gap between 8 and 12 years, of which psychologists are aware. It is a period of growth in preparation for adolescence and the move toward adulthood, it is a transitional process.

This span of time also contains the beginning of puberty.

Cognitively this is well understood, researchers showing that the memory structures of an 8 year old are 'broadly the same' as those of an adult. However, they are unable to utilise such structures until they reach 12 – 14 years of age.

Piaget identified such developmental stages describing the ages of 7 to 11 years as the stage of 'concrete operations,' understanding the world in a practical, yet logical way. This then transitions from 12 years through adolescence into the formal operational stage where many, but not all, are able to use and manipulate abstract concepts; this is a level of 'higher thinking.'

One should also consider, Piaget was born in 1896 and died in 1980, developing his theories from the 1920's onward.

Lev Vygotsky (b. 1896, d. 1934) also developed a model of cognitive development, with developmental changes, which he called 'crises' aged 1 year, 3 years, 7 years 13 years and 17 years, each level enabling the development to the next.

Vygotsky saw learning and development as interactive and as such, influenced by 'environmental factors.'

The point is, the WHO in its view of childhood, reflects long-standing, proven theories, of child development which in turn, as shown above, leads toward higher levels of thinking in adolescence and into early adulthood.

WHO ICD-11 note how diagnosis of gender incongruence/GD, cannot be assigned prior to puberty = primary school children would be excluded.