



SAFEGUARDING TRANS-IDENTIFIED CHILDREN AND ADOLESCENTS

*Safeguarding considerations for
Trans-identified pupils in schools*

Version 1.1

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Introduction

[Bayswater Support Group](#) represents over 450 parents across the UK who are seeking evidence-based care for trans-identified adolescents and young people.



For many of our children, the trans identity began - and was solidified - in school.

We have come to understand that when a child says they are trans, standard safeguarding procedures can be overlooked or overridden - *because* of the trans identity.

Key risk factors for trans-identified children:

Overlooking and failing to address other issues: e.g. ASD, ADHD, mental health issues, eating disorders, sexual abuse/other trauma, severe bullying, confusion over sexual orientation (e.g. internalised homophobia).

Likelihood that a student may take harmful physical steps to change their body in line with their attested gender identity, e.g. binding, tucking, hormonal interventions, including circumventing NHS protocols by procuring items online.

Exposure to inappropriate/inaccurate online information and/or adult influence (including explicit sexual content).

Parental alienation due to a culture where children are encouraged to keep secrets from anyone they suspect may ask questions about their desire to socially/medically transition.

We hope that policymakers at the national level, as well as senior leadership teams at the school and council levels, will use this as a guide to reprioritise safeguarding in the best interests of all children.

This document was prepared with the help of experienced safeguarding and medical professionals who provided invaluable feedback, guidance and advice.

Context

Over the last decade, there has been a huge rise in the number of children and adolescents who make sense of themselves through a transgender identity. The current demographic is very different from the cohort of young people who presented with a cross-sex identity prior to 2010: they are [older](#)¹ (mostly adolescents rather than young children), predominantly female (males previously outnumber females 3:1), have [higher levels of co-morbid conditions](#)² (such as mood disorders, self-harm, autism) and are [more likely to seek medical and surgical interventions](#)³.

These significant changes are also highlighted by the Cass Review, an independent review of NHS England's gender identity services for children and young people. The [Cass Review](#)⁴ Interim report (February 2022) refers to a "rapid change in epidemiology" and describes the mix of young people presenting to services as "more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs".

Cass also emphasises that "some children and young people will remain fluid in their gender identity up to early to mid-20s" and says that social transition (changing name and/or pronouns) is "not a neutral act" but must instead be viewed "as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning".

There is also some evidence that children and young people are expressing a transgender identity in [clusters](#)⁵. The reasons behind this are unknown, but some feel that social contagion may play a part. Many schools have already seen a dramatic rise in the numbers of children within friendship groups who wish to adopt new gender identities.

Just because something is shown to be socially contagious, this doesn't necessitate that all disclosures should be treated as though they are fictitious. Suicide and self-harming behaviours have been shown to be socially contagious, but we still take all instances seriously in order to reduce risk. Likewise, when a child comes to conclude that they have a transgender identity, this should not be dismissed off hand or trivialised. The thoughts and feelings behind the identity can and should be validated without necessarily agreeing that the singular outcome is transition.

There is now an increasing population of young people calling themselves '[detransitioners](#)'⁶ who were socially transitioned as children, adolescents or young adults. The historical data on regret and detransition has not only been very limited, but was also focused on a very different population, with more stringent criteria to gain access to medicalisation. Further information and follow up of this new cohort of young adults who regret their transition will give us further insights as to the reasons and ways in which young people land upon transition as a solution to many different difficulties.

Safeguarding

[Keeping Children Safe In Education](#)⁷ (2022) (KCSIE) defines safeguarding as:

- Protecting children from maltreatment
- Preventing the impairment of children's mental and physical health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and
- Taking action to enable all children to have the best outcomes

Many LGBT charities and support groups have worked hard to ensure the acceptance and inclusion of young people who come under their umbrella, and rightly so. However, one area of change in which they have been particularly successful - and one which we would argue could be detrimental to the safety and wellbeing of all children - is the insistence that a transgender identity is not a safeguarding issue.

KCSIE (2022) also states that a child being LGBT is not in itself an inherent risk factor for harm. We would essentially agree but wish to add an important qualifier: unlike a disclosure of sexuality, a declaration of a transgender identity should be seen as an indicator of significant and sometimes serious underlying difficulties and experiences which are indeed safeguarding risks.



Exercising professional curiosity and knowing what to look for is vital for the early identification of abuse and neglect so that staff are able to identify cases of children who may be in need of help or protection.

Keeping Children Safe in Education (2022)

Furthermore, the accommodations requested by and provided for a child who identifies as trans can also create safeguarding risks, both for the individual and their peers. We would encourage all educational and health service providers to carefully assess each child who presents with a transgender identity, together with the setting they are in, through a safeguarding lens to ensure all children are kept safe.

Many parents who have sought support from Bayswater Support Group have expressed their dismay that their trans-identified child, rather than be the subject of rigorous

safeguarding protocols, is removed from the safeguarding frameworks altogether. This does the child a disservice and is potentially in itself a discriminatory act.

All children deserve protection from harm, and trans-identified children and young people should not be the exception.

Legal and Statutory Guidance

There are several legislative, statutory and non-statutory guidance documents which underpin the responsibilities towards keeping children safe from harm. These include:

- [Keeping Children Safe In Education](#) (2022)⁷
- [Working Together To Safeguard Children](#) (2018)⁸
- [The Equality Act 2010](#)⁹
- [The UN Convention on the Rights of the Child](#)¹⁰
- [Relationships and Sex Education and Health Education Statutory Guidance](#)¹¹

KCSIE (2022) states that:

“in the context of safeguarding, this guidance, and the legal duties placed on schools and colleges in relation to safeguarding and promoting the welfare of children, governing bodies and proprietors should carefully consider how they are supporting their pupils and students with regard to particular protected characteristics - including disability, sex, sexual orientation, gender reassignment and race.”

The Public Sector Equality Duty is part of the Equality Act. KCSIE summarises schools' obligations under PSED:

“PSED places a general duty on schools and colleges to have, in the exercise of their functions, due regard to the need to eliminate unlawful discrimination, harassment and victimisation (and any other conduct prohibited under the Equality Act), to advance equality of opportunity and foster good relations between those who share a relevant protected characteristic and those who do not. The duty applies to all protected characteristics (see para 87) and means that whenever significant decisions are being made or policies developed, specific consideration must be given to the equality implications of these.”

Advice on the [legal obligations for schools](#)¹² was clarified in August 2022 by the then Attorney General Suella Braverman. Ms Braverman noted the Cass Review findings about the consequential nature of social transition and warned that “schools and teachers who socially transition a child without the knowledge or consent of parents or without medical advice increase their exposure to a negligence claim for a breach of their duty of care to that child”. She suggested that a decision to agree to social transition should only be taken “after all safeguarding processes have been followed, medical advice obtained, and a full risk assessment conducted, including taking into account the impact on other children.”

In terms of compliance with the Equality Act, Ms Braverman noted that schools may lawfully “refuse to use the preferred opposite-sex pronouns of a child”, explaining that “This does not necessarily constitute direct discrimination on grounds of sex, particularly if unsupported by the child’s parents or unsupported by medical advice. Nor is it necessarily indirect discrimination on grounds of gender reassignment [...]”. With regard to the provision of single-sex services under the Equality Act, Ms Braverman emphasised that “a right not to suffer discrimination on grounds of gender reassignment is not the same thing as a right of access to facilities provided for the opposite sex.

A Note on Gender Identity Theory

Gender identity theory is an ideological concept that promotes the idea that an individual can be “born in the wrong body” due to a mismatch between biological sex and an inner feeling of being man or woman, boy or girl (a so-called gender identity). It states that everyone has a gender identity and that if there is no incongruence between sex and gender identity an individual is ‘cis’ and if there is, they are ‘trans’. It advocates that feelings of masculinity, femininity and the concept of gender identity, should take precedence over the biological reality of sex. It has been used to erode the boundary between the concepts of male and female, adult and child due to the heavy influence of queer theory. It is a highly contested conceptual framework, but has already been presented to many schools as ‘settled science’.

Given the poor evidence base to support gender identity theory as fact, this ideology should be treated in a similar way to other belief systems or philosophies. The known facts about the immutability of sex should be presented together with the understanding that not everyone believes themselves to have a gender identity and that holding different beliefs is not a negative position, but should be the basis of respectful, open discussion. Approaching gender identity theory in this way does not preclude the compassionate and thoughtful support of a child or young person who is distressed or confused about their gender, in the same way that providing a balanced view of Christianity or Islam does not preclude the support of pupils who are Christian or Muslim.

Gender Identity theory is one way of understanding why a child may feel discomfort with their sex. Understanding there are myriad reasons why a child may come to make sense of themselves through a transgender identity leads to the conclusion that there may be many different outcomes for this cohort of children and young people. Each child is unique and should be valued and treated as such.

However, there are many potential harms associated with unquestioningly treating children as though they are actually the opposite sex. School staff are not in a position to make a full biological, psychological and social assessment or choose which interventions should or should not take place, without extensive consultation with medical professionals, parents and carers as well as the individual young person. All adults who have responsibilities towards a child must work together to ensure the best interests of the child are served, both in the short and longer term.

CHILD AND ADOLESCENT TRANS IDENTITY

The tip of the iceberg?

SOCIAL TRANSITION

Requesting a name and pronoun change, clothing and hairstyles, and requesting to use facilities designed for the opposite sex

TRANS IDENTITY

When a child or adolescent declares a trans identity, many see this as the end point - a simple declaration of an internal state. However, immediate affirmation of the new identity often overshadows the background circumstances that led to this conclusion.

Mental Health

Depression, anxiety
Emerging personality disorder
Self-harm and suicidal behaviour
Eating disorders
Trauma

Sexuality

Lesbian/Gay/Bisexual
Internalised homophobia
Homophobic peers or family
Homophobic bullying

Neurodevelopment

Autism
ADHD

Social Factors

Bullying
Social isolation
Adoption/foster care
Bereavement
Non-conformity to sex stereotypes

Safeguarding Issues

Sexual abuse/exploitation
Inappropriate online activity
Grooming/coercion
Radicalisation
Online sexualisation
Illegal hormones
Binders & tucking

Puberty

Social influence
Body discomfort
Sex and relationship education
Identity formation
Periods
Peer pressure

Bayswater

In a survey of our members:



Bullied



LGB



Autism/ADHD

www.bayswatersupport.org.uk

Tip of the iceberg: The presentation of a trans-identity must be seen as the visible component of a complex presentation, with contributing factors and safeguarding issues needing to be identified and addressed as appropriate

What Safeguarding Issues are Raised by a Transgender Identity?

Far from being a simple statement of an internal state of being, there are a wide range of risks that are flagged when a child or young person starts to make sense of themselves through the lens of gender identity. From neurodevelopmental conditions and mental health issues to background bullying and online harms, a holistic overview of the identity must be taken in order that no safeguarding issues are overshadowed or ignored.

Neurodevelopmental conditions

Autistic children have the right to be protected from harm and often possess characteristics which make them [more vulnerable to abuse](#)¹³. Difficulties with social interaction, interpretation of motives and dangers and differences in communication style can not only make an autistic child more likely to be a victim of abuse, but may make it more difficult for them to communicate and report harmful experiences.

Data from the UK has shown that [Autism Spectrum Conditions are more prevalent](#)¹⁴ in trans-identified adolescents than the general population, possibly [up to 25%](#)³ of individuals having clinically significant traits and replicated across many countries. A recent audit of the adult gender service in Ireland expects to find [up to 90% may have autism or autistic traits](#)¹⁵, up from just 3% in 2014. A survey of Bayswater members in 2020 revealed that 30% of their children have an autism diagnosis, and a further 11% were under assessment. The reasons for this link are unclear, but it may be that differences in social awareness of gendered behaviours, black-and-white thinking, bullying, same-sex attraction, sensory processing difficulties and feelings of otherness and isolation from peers may contribute to the child viewing their distress as gender-based. Awareness of the possibility of an undiagnosed neurodevelopmental condition in this population is vital to ensure appropriate assessments and referrals take place.

From a safeguarding perspective, the presence of a neurodevelopmental condition could mean a child is more susceptible to undue influence, bullying, and inappropriate online interactions. As such, they will need appropriate support within school and educational settings.

Research suggests that [individuals with ADHD are also more likely to express 'gender variance'](#)¹⁶. ADHD is linked to poor planning and decision-making, impulsivity, and delayed cognitive maturity. It also impedes socialisation, leading to feelings of isolation. All of these factors can combine to make a trans identity seem an attractive solution to resolve social isolation and the underlying distress from being rejected by peers. The impulsivity of young people with ADHD puts them at additional risk for drug taking and other risky behaviours (sexual exploitation, self-harm, speaking to predatory strangers they may encounter when attempting to explore their identity).

Mental health

In the majority of young people presenting to gender clinics, there are [higher rates of mental health co-morbidities](#)¹, many of which are severe. These can include anxiety, depression, psychosis, conduct disorders and substance misuse. As mentioned previously, autism and ADHD are also overrepresented in the trans-identified population. These co-morbidities can often predate the declaration of a trans-identity, sometimes by years.

Keeping Children Safe in Education (2022) states that:

“All staff should be aware that mental health problems can, in some cases, be an indicator that a child has suffered or is at risk of suffering abuse, neglect or exploitation.”

School staff must remain mindful that the majority of trans-identified children and young people will have other mental health issues. Therefore a declaration of a transgender identity should flag that there may be safeguarding issues relating to mental health that need to be identified and addressed.

KCSIE makes it clear that *“Only appropriately trained professionals should attempt to make a diagnosis of a mental health problem.”* Teachers do not have the required qualifications to diagnose gender dysphoria, but are able to observe and document behaviours which may indicate that a child or adolescent needs an assessment of their mental health and signpost to appropriate services. Even with a diagnosis of gender dysphoria, it does not follow that social and medical transition are the only ways to alleviate distress, or that transition is the only possible outcome. However, evidence shows that social transition appears to be the main predictor of persistence in a transgender identity.

The duty placed upon teachers to report a child who has a mental health condition that is also a safeguarding risk is clear: take immediate action, follow the local child protection/safeguarding policy and inform the safeguarding lead or deputy safeguarding lead. Children who have a transgender identity should not be removed from these universal safeguarding principles. To do so is to deliberately put them at risk.

Depression & Anxiety

There has been significant attention over recent years to the [rising incidence of adolescent mental health issues](#)¹⁷. The underlying causes are many and complex, with long waiting lists for children and young people's mental health services. It has been shown that many children with identity issues are also suffering with [depression and anxiety](#)¹. Careful assessment of a child or young person's psychological wellbeing is essential in keeping them safe from harm. Knowing that trans-identified children and young people are at risk of depression or anxiety can help parents, carers and educational staff be alert to possible signs of deteriorating mental health.

It is worth noting, however, that some methods for addressing potential mental health issues may run the risk of creating the problem they have been designed to prevent. In one study, delivering a universal, CBT-based preventative programme actually [increased internalising symptoms](#)¹⁸ (feelings and emotions associated with anxiety or depression). There is also evidence of a similar effect with [mindfulness techniques](#)¹⁹. There is a risk that without professional training, an understanding of the evidence and relevant experience, teaching staff may inadvertently make a situation worse.

Eating Disorders

Trans-identified young people are more likely to report [disordered eating behaviours](#)²⁰ than their peers, and higher utilisation of weight loss interventions such as laxatives and diet medications. The reasons for this are unclear, but bodily dissatisfaction is thought to be one of the processes by which those with a transgender identity also develop disordered eating.

Discomfort over breast and hip development and a desire to halt menstruation can lead to efforts to achieve weight loss in females. Conversely, a female may wish to gain weight in order to appear more masculine and reduce attention to their bodies. Males may wish to lose muscle mass to meet their internal image of what a female body should look like. Those with a non-binary identity may also wish to reduce body mass to achieve the societal view of androgyny. The desire to pass as a member of the opposite sex and conform one's body to an internalised ideal can be powerful driving forces.

Disordered eating in neurodevelopmental disorders is also well documented, and may be an additional factor in those who are trans-identified.

Interestingly, it remains the female population of trans-identified people who remain at highest risk of eating disorders. Awareness and appropriate referral or intervention should be assessed if it is thought a child or young person is suffering from or at risk of developing an eating-related disorder.

Self-harm and suicide

If a child or adolescent expresses thoughts about self-harm or suicide it is important to always take them seriously and seek appropriate help through local safeguarding procedures.

Studies have shown that adolescents and young people with a trans identity are more likely than their peers to [experience self-injurious thoughts and behaviours](#)²¹, including suicide. The reasons for this are many and complex: the high rate of co-morbid conditions, such as anxiety, depression, autism and bullying are all factors that may contribute. Keeping these reasons from parents is not helpful, and does not aid in keeping the young person safe.

Attributing suicide or self-injurious behaviours to a single cause, such as a trans identity and whether or not this is affirmed, is irresponsible and goes [against the advice of leading suicide prevention charities](#)²². Suggesting to young people that they are more likely to take their own lives is encouraging the well-documented [social contagion of suicidal behaviour](#)²³. The presence of any thoughts or intentions of self-injurious behaviours should be regularly assessed according to local safeguarding procedures, which may include disclosure to parents or mental health professionals. Absolute confidentiality should never be promised to a child and safeguarding protocols must make staff aware that they are obliged to share information with relevant people regarding self harm or suicidal thoughts in order to keep the young person safe.



The majority of the children and young people we see do not self-harm, nor do they make attempts to end their own life. Although there is a higher rate of self-harm in the young people who are seen at GIDS compared to all teenagers, it is a similar rate to that seen in local Child and Adolescent Mental Health Services (CAMHS).

The Gender Identity Development Service Website²⁴

It is important to remember that parents who may not necessarily support the social transition of a child who expresses distress about their gender should still be kept apprised of their child's thoughts of self harm or suicide according to local safeguarding practices. Parents should be presumed to have their child's best interests at heart in the absence of evidence to the contrary and part of keeping them safe will involve sharing with them important information about their child's wellbeing.

Trauma/sexual harassment/sexual abuse

A background of [trauma linked to sexual abuse or harassment](#)²⁵ is very common amongst trans-identified youth. This can be anything from peer-on-peer abuse, child grooming or even incest. It is well known that severe, prolonged abuse, especially if of a

sexual nature, can lead to complex PTSD. This is linked to very serious mental health conditions, including those which directly relate to body dysmorphia, eating disorders, self-harm and gender dysphoria.

Other forms of trauma found more often in individuals with a transgender identity are linked to attachment issues mediated via adverse childhood experiences (ACE), such as adoption, prematurity and being placed in care.

[Unresolved trauma](#)²⁶ is one of the most frequently cited reasons for mistaken belief in being trans by detransitioners. However, there is no definitive answer to the question of whether some forms of childhood trauma are actually a causative factor in the development of a transgender identity or presentation of early childhood non-conformity, rather than a simple correlation. The new cohort of young people presenting with a transgender identity, who are less likely to have been gender non-conforming from early childhood, requires is to be mindful that childhood trauma could result in a transgender identity, at least in some young people, as an [attempt to avoid or resolve psychological distress](#)²⁷.

There has been growing concern about the [prevalence of sexual harassment among school peers](#)²⁸. In 2020, the website [Everyone's Invited](#)²⁹ began cataloging young people's experiences of the normalisation of sexual violence and sexual harassment within the school environment. The project triggered OFSTED to launch a rapid [review into sexual harassment in schools](#)³⁰. They found that sexual harassment, sexualised language and sexual abuse, both in person and online, was highly prevalent within both schools and the wider community. In some cases, it was so prevalent that children and young people did not feel able to report instances.

We know from the accounts of young detransitioners that experience of sexual harassment or abuse were factors in their decision to transition, and that these experiences were poorly dealt with in favour of celebrating the new transgender identity. These young men and women are now left with not only unresolved trauma, but the long-lasting effects of medical and surgical transition to alleviate their mental distress. Schools have a duty to identify and support any young person who may have experienced trauma, or who may have landed upon a transgender identity to escape other forms of mental distress.

The Department for Education has produced [advice on tackling sexual abuse between children in schools](#)³¹.

Bullying

A survey of Bayswater parents in 2020 showed that over 80% of our children had been bullied at school. Over half of the responses stated social non-conformity as a reason for the bullying, and a further 25% stated that sexuality was the driving factor. Very few cited gender non-conformity as a sole reason for being targeted by peers. There is published literature showing similar patterns and in one study, almost all the cited

[bullying took place before a trans identity](#)¹ whereas only a minority were bullied after they began to explore their gender.

Bullying is a problem in all schools, and being trans-identified may be an indicator that a child has been targeted - something that may or may not have been brought to the attention of staff. To ensure the safety of all young people, it is vital to acknowledge the presence of bullying, note the nature of any harassment, and ensure a zero-tolerance culture through the use of evidenced interventions and a whole school approach.

Homophobic bullying

A gender non-conforming child is three times more likely than their peers to grow up to be a lesbian, gay or bisexual adult. A quarter of Bayswater Members revealed that their child had been the victim of homophobic bullying and a little over half of them had come out as lesbian, gay or bisexual before declaring a transgender identity. A significant number of detransitioners have also revealed that [internalised homophobia](#)^{32 26} was one of the [contributing factors](#) to their desire to transition in the first place.

This explanation has been echoed by GIDS clinicians, who expressed concern that many gay and lesbian children were adopting a transgender identity, sometimes fuelled by parents who would [rather have a transgender child than a gay one](#)³³. There is growing concern that pursuing medical transition could hinder the development and acceptance of same-sex attraction.

The best evidence we have shows that as many as 80% of those who have a cross-sex identity in childhood will [grow up to be lesbian, gay or bisexual](#)³⁴. Professionals need to be alert to the understanding that, for some young people, a trans identity can be more acceptable, both to the young person and their peers, than a lesbian, gay or bisexual orientation, with transition being a form of self-imposed conversion therapy.

Online safety

Sexualisation, predatory behaviours, CSE and grooming

When first exploring a new identity, young people almost [exclusively turn to online platforms for advice and guidance](#)³⁵. Many of the forums for young people exploring their sexuality and identity will - by nature of the subject - display content which may be sexually explicit or age inappropriate. Young people may be taken under the wing of older, more experienced individuals, without any guidance from parents or other safeguarding-informed adults.

Some individuals may genuinely wish to help a young person to explore their identity, and provide advice based on their own experience, but some young people may find themselves sharing very intimate thoughts and feelings with strangers online. This raises huge red flags and opens the young person to the risks of grooming and possible CSE.

Grooming³⁶ occurs when “*someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them*”. A common grooming technique is for adults to provide children with items, causing them to feel obliged to do or say something in return. Young trans-identified people can be given access to breast binders, prosthetic genitals to give the appearance of a penis (packers), as well as clothing and other items from unknown individuals they have met online. These garments and devices are provided with little or no parental guidance, knowledge or input.

Remember that Child Sexual Exploitation does not need to involve physical contact, it [can occur through the use of technology](#)³⁷. Unsupervised online access, sharing of sexual images, being bought items which affirm the child or young person’s transgender identity can all be used as a way to manipulate a child into sexual activity.

This may raise memories of the paedophile allegations levelled at lesbian and gay communities of the past. When it comes to safeguarding, however, we must all create a culture of vigilance, where no individual, organisation or community is above suspicion or investigation. Past injustices against one group should not preclude thorough consideration of all the risk factors for an individual child.

Professionals need to be alert to the likely sources of information children and young people are using, and the risk that these could advise children not to trust the adults in their lives. Many sites will promote the idea that most parents and adults will not understand, and are likely to reject the child due to their newfound identity. This is a significant risk factor for behaviours that can alienate the child from their support networks and expose a vulnerable child to further grooming or exploitation.

Young people need to be encouraged to speak with their parents, or qualified and regulated adults who understand robust safeguarding procedures and how to provide support for young people. They must also provide comprehensive education on the dangers of confiding in strangers on the internet. Nobody is above suspicion when following safeguarding best practice. This includes the understanding that anyone, from any background, can carry out the sexualisation, grooming or sexual exploitation of a child.

Illegal drugs

Many young people who have spent any time thinking about a transgender identity often ‘come out’ alongside a request for immediate medical intervention, something they have often spent many hours researching online. With waiting lists for gender clinic assessment being several years, many young people find their way to online forums which advise and encourage young people to pursue a [‘DIY’ medical transition](#)³⁸ by obtaining medications illegally online. They may well have come across websites that offer medications in ‘stealth’ packaging, often from unregulated sources abroad, for prices that are well within the budget of many young people.

This is a significant risk for several reasons. The advice young people receive from strangers on the internet is often incorrect and dangerous. The dubious provenance

and uncertain contents of these medications, the lack of documentation and disclosure of which medications they are taking can risk drug interactions for unrelated health problems. Some medications sourced from abroad are illegal to possess without a prescription, and often have serious and long term health consequences. Medical transition should **only** be undertaken with significant and trustworthy input from qualified medical professionals, after a comprehensive period of assessment. This is a situation which safeguarding professionals must be alert to if they are to ensure that young people are protected from doing themselves significant harm.

Social Transition

Social transition is a catch-all term used to describe the non-medical, non-surgical steps a person takes to present as a member of the opposite sex or, in the case of non-binary and other identities, in a sex-neutral way. It can include alterations to hairstyles and clothing, changes of name and pronouns, using the changing and toilet facilities of the opposite sex, taking part in sporting and other activities that are segregated by sex. The purpose of social transition is to alleviate the symptoms of gender dysphoria, though there is no robust evidence that this is an effective way to reduce the feelings of discomfort in one's own body.

Historically, these steps were not taken lightly nor without significant trial of alternative methods to reduce the feelings associated with gender distress, and certainly not without oversight from a medical or mental health professional. However, with the changing social environment, young people find themselves increasingly undertaking social transitions long before having seen any professional for help or assessment of whether transition is in the best interests of the child. Educational settings are increasingly facing requests for social transition, with or without the knowledge or permission of parents. This situation is largely an unregulated social experiment.



Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an **active intervention** because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is **not a neutral act**, and better information is needed about outcomes.

The Cass Review Interim Report (2022)

Social transition is a significant psychosocial intervention, one which has no defined terms or solid evidence base, and one which teachers are ill-equipped to deal with without professional clinical training. Again, we refer to KCSIE, which states clearly that *“Only appropriately trained professionals should attempt to make a diagnosis of a mental health problem.”*

Affirmation is the first step on the pathway to medical and surgical transition. Enabling this without addressing and exploring the underlying issues mentioned above risks ignoring them, making them worse, or locking in an identity that might otherwise resolve during adolescence.

The following sections cover the the main aspects of social transition that may give rise to safeguarding issues:

Name Changes

With the rising incidence of children and young people requesting to change their names in educational settings, it is important to assess the potential risk of parental [alienation and estrangement](#)³⁹. Name change is a technique that may be used to distance a child from their existing family relationships and encourage them to show commitment to a new life. It is often very different from using a nickname. Nicknames are normally affectionate familial or peer-given names, and often used interchangeably with the birth name.



The manipulation of names is a potent technique in efforts to undermine a child's love and respect for parents and other relatives. Therapists should be alert to the possibility that such manipulation signals a more general effort to alienate children, a process that can harm the children.

Understanding the dynamics and types of name manipulation can inform the advice professionals give parents about how to respond effectively in order to protect their children from becoming alienated.

Warshak (2015) Poisoning Parent-Child Relationships
Through the Manipulation of Names

In contrast, the names chosen by trans-identified young people have a very specific purpose: to signify leaving behind who they were, embracing their new gender and often synonymous in the child's mind with membership of the opposite sex or of no

specific sex in the case of non-binary identities. It is a cornerstone of social transition that comes with many unintended consequences and risks. Use of the previous name becomes taboo and is referred to as a 'dead name'. If not approached with care and forethought, adult compliance with a new name can signify agreement with the child that the person they were is somehow defective or in need of replacement, contributing to a widening distance between the child and their body as well as between parent and child.

The context of this name change can be seen as analogous to renaming on joining a new religion or a coercive group, and as such should be considered as a safeguarding red flag. On school premises, name changes may cause difficulties identifying a child in an emergency situation, especially if the parents are unaware. Extreme caution needs to be exercised in agreeing to formalise any request for a name change, and should not happen without parental consent. This decision should always be discussed in detail with parents, taking care to highlight the significance of the decision. (See also the next section on [absolute confidentiality](#).)

There is evidence from studies on [parental alienation](#)³⁹ that name changes can create a significant impact on parent-child relationships, and are not necessarily the benign act they may seem. Changing a child's name should not be undertaken without considering the full impact of such an action.

Absolute confidentiality

Some of the resources for supporting a trans-identity in school claim the disclosure of a trans-identity by a child, adolescent or young person should be subject to absolute confidentiality. One of the main tenets of safeguarding is that no adult should promise to keep secrets for a child, and appropriate information sharing is another of the core principles of safeguarding. When supporting a child with a trans identity, this rule still applies, and remains essential to ensure the safety of that child.



Staff should know how to manage the requirement to maintain an appropriate level of confidentiality...Staff should never promise a child that they will not tell anyone about a report of any form of abuse, as this may ultimately not be in the best interests of the child.

Keeping Children Safe in Education (2022)

Involvement of parents

Communicating with parents is a task most schools do incredibly well, considering the huge diversity of the parent community from any given school. Maintaining open lines of communication with parents and a culture of co-operation and information sharing is essential if the best outcomes for children are to be achieved.

Article 18 of the UN Convention on the Rights of the Child highlights the central, pivotal role that parents have in raising their children. It recognises that a child's best interests are their basic concern. Article 5 of the same Convention outlines a child's right to be guided by parents *alongside their evolving capacity to make their own decisions*., and recognises the importance of the family environment.

"Anyone working with children should see and speak to the child: listen to what they say; take their views seriously; and work with them **and their families** collaboratively when deciding how to support their needs." - Working Together to Safeguard Children (2021)⁸ [our emphasis]

We have highlighted how a trans identity should be seen as an indicator of potential safeguarding risks and prompt careful assessment. It can be a proxy for multiple problems that need sensitive discussion involving parents. It is *not* a reason to remove any child from safeguarding frameworks altogether. Failing to seek parental input, or preventing parents from being fully informed of their child's social and emotional wellbeing puts an already very vulnerable child directly in harm's way.

Many organisations cite the likelihood of unsupportive parents as a reason to assume a non-disclosure approach, and liken the situation to the outing of a non-heterosexual orientation. But a lesbian, gay or bisexual orientation does not require changes in language (new name or pronouns), social transition or lead to medicalisation. Though it may be good practice to remain mindful that many of the risks that are present for the trans-identified child or young person may also apply to those who disclose a non-heterosexual orientation (for example sexualised online activity, contact with unknown adults online and bullying from peers)

There are other issues that arise from keeping a social transition secret from parents. Staff will need to lie intentionally or by omission about the use of names, pronouns and possibly mixed sex changing facilities. There is a very real risk that parents will find out from third parties, as hiding a transition from other members of the school community is an almost impossible undertaking, and 'outing' to parents by staff, pupils or other parents is a real risk.

In order to safeguard any child or adolescent effectively, all parties must work together. Keeping secrets and lying to parents undermines the working relationship with parents and destroys honesty, trust and integrity on the part of the school, which can itself create further safeguarding risks.

Organisations should not hide behind blanket confidentiality rules which undermine safeguarding. If it is believed that disclosing information to parents would pose a

safeguarding risk to a child, local procedures must be initiated, keeping careful documentation of all conversations and decisions.

Remember: the child is likely to have been coached online or by peers that parents will reject them, so the words and ideas of the child may not always be their own. If a parent does not support the pursuit of full social transition, this does not mean that a parent does not provide adequate care and support for the child. Support in this context should not require a fundamental belief in transition as a solution. Often the parent has a perspective on the child's development that is often not seen by educational settings.

Binding and Tucking

Binding is the use of constrictive materials to compress breast tissue and give the appearance of a more masculinised chest. Bandages, tape, ill-fitting sports bras and purpose-made garments are used to create the appearance of a flattened chest. It is suggested that these reduce gender dysphoria and even suicidality, but there is no robust research into this area and therefore [no solid evidence to support these claims](#)⁴⁰.

The long-term effects of breast binding on young girls and adolescents before the heart, lungs, spine and ribcage have had time to mature are simply not known as there has been a sad lack of research. The only [large-scale study](#)⁴¹ showed that **97%** of women and girls who bind experience side effects ranging from breathlessness and dizziness to skin infections, fractured ribs and scarring. Surprisingly, it is the purpose-made 'binders' that are associated with the highest rate of side effects.

The wearing of a binder or use of binding materials, may superficially make the young girl feel better. But binding in all its forms should be considered a form of self-injurious behaviour, and approached in a similar manner. Safeguarding protocols for reporting and supporting an individual who is self-harming should also be followed in these circumstances.

As binding in all its forms restricts the breathing of the young person, they should not be allowed to be used in school. Well-fitting compression sports bras are a possible alternative. Bandages or fabric that encloses the circumference of the chest cavity should also not be allowed in any school setting.

For a more comprehensive look at the harms associated with binding, please see [Binding: Self Harm or Gender Care?](#)⁴⁰

Tucking of the genitals is the process by which males hide the appearance of their external genitals. There is again no extensive research evidence demonstrating the benefits or harms of such practices. However, there are already documented cases of testicular torsion (a medical emergency) from tucking, and any condition which raises the temperature of the testes can predispose to testicular cancer. This is a harmful practice that should not be allowed on school premises, and actively discouraged. Any disclosure of pain or discomfort related to the practice of tucking should be urgently reported to a medical professional.

A Note on Gillick Competence

Children 16 and over are deemed competent to consent to their own medical treatment, unless proven otherwise. Those aged 15 and under may have the capacity to consent to treatment if they are assessed as being Gillick competent. This means that the child must demonstrate⁴²:

- the ability to understand that there is a choice and that choices have consequences
- the ability to weigh the information and arrive at a decision
- an understanding of the nature and purpose of the proposed intervention and of the intervention's risks and side effects
- an understanding of the alternatives to the proposed intervention, and the risks attached to them
- freedom from undue pressure

Just because a child is competent to consent to treatment in one situation, (eg. the administration of paracetamol for a headache), does not mean they have the capacity to make all medical decisions. The General Medical Council makes clear the specificity of Gillick:

“It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made. You should remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences. The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment.”⁴³

Both the British Medical Association and the GMC make it clear that every effort should be made to persuade a young person to involve their parents in their decision-making. When deciding what is in the best interests of a child, one factor clearly highlighted by the GMC guidelines is “which choice, if there is more than one, will least restrict the child or young person's future options.”

Diagnosing mental health conditions is beyond the competence of teaching staff and many school counsellors. Teachers are highly unlikely to be in a position to explain or discuss the current state of evidence on which interventions are best suited to any particular child who presents with distress about their gender, taking into consideration their individual medical and psychological history, together with their social situation. We would advise that this assessment, together with the implementation of any subsequent medical interventions (which includes social transition), is only made by qualified clinicians who hold clinical accountability.

Policies

Every child deserves the right to fully participate in school life, free from harassment and discrimination, and schools across the country have adopted policies designed to allow trans-identified pupils maximum inclusion in school life, in accordance with the provisions in the Equality Act 2010. However, many of these policies fail to balance the rights of other protected characteristics, or address situations in which the rights of two or more groups may come into conflict.

Equality policy

The first step in protecting all groups under the Equality Act 2010 is to list them correctly. Many lobby groups have attempted to “get ahead of the law” by encouraging listing characteristics such as “gender” and “gender identity” that are neither defined nor protected under the Equality Act.



If we cannot be clear about what characteristics are protected, we cannot ensure that we are compliant with the law. All organisations should list the [correct protected characteristics](#)⁹: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Equality Act also includes a duty to promote relations between different groups with protected characteristics. Singling out trans-identified children for special treatment without due consideration to the rights and needs of others may appear to be the right thing to do, but is likely to have the opposite effect in the eyes of peers, potentially making them the target of bullying, isolation and victimisation.

Equal rights should be afforded to everyone. But there are circumstances in which protected characteristics come into conflict - such as religion and sexual orientation, or gender reassignment and sex. These rights will need to be balanced, which is often a daunting task.

Sex-segregated spaces

The [Equality Act 2010](#)⁹ allows for the provision of single-sex facilities such as changing rooms (EA2010 Schedule 3 part 7) and sleeping arrangements (EA2010 Schedule 23). The law allows for the provision of single-sex spaces as a proportionate means to a legitimate aim – in this instance for the protection, dignity and privacy of females from members of the male sex. Just as we do not segregate male and female pupils because all males are a risk to all females, we do not assert that all trans-identified males are a risk to all females, but that the risk is assessed based on sex, not gender identity.

Changing facilities and toilets [segregated by sex](#)⁴⁴ must be provided for all children over the age of 8. Having a transgender identity does not negate the need for girls and boys to have separate areas as it does not constitute a change of biological sex. With the rising number of cases of sexual assault within schools - overwhelmingly committed by boys on girls - having a sex segregated space is vitally important to ensure the safety of all female pupils. Female pupils should not be made to feel that they are unwelcome in their own spaces, and should not be made to use alternative facilities if they feel uncomfortable in the presence of male-bodied peers.

The basis upon which we segregate boys and girls for toilets and changing rooms is the physical risk posed by mixing the biological sexes, and to allow boys and girls to have privacy and dignity away from members of the opposite sex. Allowing females who identify as boys, or males who identify as girls into the spaces reserved for the opposite sex is a safeguarding risk and should not be allowed.

It is important to remember that safeguarding is about preventing harm from occurring in the first place, not just about reacting when a child has already become a victim. Access to single-occupancy facilities should be provided if an individual child does not wish to use the facilities that correspond to their biological sex. But it is not acceptable to change all disabled changing areas and toilets to gender-neutral/mixed facilities without first ensuring adequate provision is maintained for those with disabilities.

Policies for overnight accommodation must state clearly that provision is based upon sex. There have been cases where parents have not been informed when their child has shared accommodation with a member of the opposite sex because organisations and

schools understood that an individual was protected under gender reassignment. Parents have the right to be fully informed when they consent to their children taking part in extracurricular activities. As previously stated, the risk is not derived from mixing different gender identities, but from mixing the biological sexes. There should be no exceptions to activities required to be segregated by sex.

PSHE Curriculum

Any Personal, Social and Health Education lessons taught in same-sex groups should not accommodate members of the opposite sex, regardless of how they may identify. The motive behind providing single-sex teaching is the protection of privacy and dignity and also the provision of information specifically relevant to that group, based on their shared biology. For instance, it is inappropriate for a group of male children to be taught about intricacies of male puberty in a same-sex group but with the presence of a biological female peer. It is also essential that young girls and boys, however they identify, are provided with teaching appropriate to the pubertal changes their bodies are expected to go through.



As with any visitor, schools are responsible for ensuring that they check the visitor or visiting organisation's credentials. Schools should also ensure that the teaching delivered by the visitor fits with their planned programme and their published policy.

Department for Education Statutory Guidance
on relationships and sex education (RSE) and health education

Government guidance on teaching PSHE is clear that any lessons delivered by external providers should be thoroughly checked by staff members. The school must see copies of materials and a full lesson plan before allowing an external agency to deliver a lesson or presentation. The school also has a duty to check the safeguarding credentials of any individual who will have direct contact with students, in accordance with local safeguarding protocols.

Materials should never assert that an individual is a member of the opposite sex, or may have a different gender identity based upon sexist stereotypes such as clothing, hairstyle, toy or activity preferences. PSHE lessons should be non-partisan, and not teach ideological positions as fact. For instance, some people may feel that they have a gender identity that differs from their biological sex. It does not follow that everyone has a gender identity, or that those who present in a manner atypical for their sex is

necessarily transgender. It should be made clear that this is a political and ideological standpoint and that other views and beliefs about sex and gender exist.

The DfE guidance also places emphasis on an open and transparent approach to parents, including:

- Awareness that parents have the most significant influence on their child's development
- Schools should work closely with parents when planning and delivering RSE
- Materials and resources used in curriculum delivery should be shared with parents
- Parents have a right to request their child be withdrawn from all or parts of the sex education curriculum

Schools should always consult with parents on their [PSHE curriculum](#)¹¹. The Statutory guidance advises that parents should be given access to the resources being used to teach this area. A culture of openness and transparency should be encouraged. Claims of copyright infringement should not be used as a reason for withholding resources from parents - materials can be shown without having to distribute copies by giving access to resources on school premises.

Sports

There has been increasing coverage of the controversy surrounding the participation of trans-identified individuals in amateur and professional sport. It is undeniable that the experience of a male puberty confers physical advantages to an individual when compared with a biological female. At competitive levels, this equates to an unfair advantage.

Sports within schools, if deemed to need segregating on the basis of sex for safety reasons, should continue to be. Schools should ensure that as many sports as possible are accessible to all, and should think carefully about whether providing different sports for different sexes is necessary or fair. Many children dislike playing sports traditionally thought of being for a particular sex, for example netball for girls and rugby for boys. Schools should look to ensure all girls and boys have equal access to all sports, or playing mixed non-contact sports should be encouraged. Schools must undertake adequate risk assessments when considering the provision of mixed-sex sports.

LGBT Clubs

Whilst the added support provided to young people who may be struggling with issues around sexuality is a legitimate aim of LGBT clubs, recent UK news articles have reported on extreme beliefs and practices being promoted in some school-time and extra-curricular LGBT clubs. For example, an English school in which [18-year olds advised 11-year olds on wearing binders](#)⁴⁵ and presented ideological and contested concepts as fact. These clubs may inadvertently encourage the viewing of explicit sexual content through signposting to online content. Some groups have been

encouraging social, medical and surgical transition under the guise of information provision. In some circumstances, the activities are overtly political or activist in nature, which contravenes schools' duty to impartiality and non-partisan views as laid out in government guidance.

To prevent inappropriate adult themes or extreme beliefs being presented as fact to children on school premises these clubs, if present, must be supervised by a safeguarding trained member of staff who is accountable for all activities. Parents should be informed when their child attends politically active or unsupervised clubs, and should be made aware of any controversial topics that may be covered in order to provide an opportunity for discussion at home according to the values held as a family.

Safer Recruitment

There have been increasing numbers of reports in the media about the failures in safer recruitment of staff working with children, leading to unsuitable candidates being employed. This may be because of fears of being accused of prejudice against individuals who have protected characteristics, or simply poor pre-interview screening..

All staff, regardless of their sex, sexual orientation, gender reassignment status, race, religion, disability or other protected characteristic should be subject to rigorous safer recruitment practices, including assessment of online and social media presence, as suggested in KCSIE (2022). The safeguarding of children takes the utmost precedence and no protected group should be placed outside of the necessary scrutiny required by safer recruitment guidelines.

Radicalisation

Within safeguarding frameworks, there is existing awareness that many children and young people are vulnerable to radicalisation. With the intense online immersion experienced by many trans-identified young people, it is worth being mindful that many of the vulnerability factors and indicators of radicalisation are found within the population of trans-identified young people. This does not mean that all trans-identified youth have been radicalised, but it is important to be aware of the overlap and the need to identify risk factors and indicators of potential radicalisation into extreme ideologies, religious or political.

Further information is available from [ACT](#)⁴⁶ and [official government guidance](#)⁴⁷, as well as school-based Prevent training.

Signs and Indicators of Radicalisation

- Being influenced or controlled by a group
- Spending an increasing amount of time online
- Being secretive about who or what they are doing online or in person
- An unwillingness to engage in dialogue about their views
- Sharing extreme views on social media platforms
- Personal crisis
- Mental Health Issues
- Desire for status
- Searching for identity, meaning and belonging
- An angry or obsessive desire for change
- Looking to blame others
- Becoming increasingly isolated from family and friends
- A young person who is talking as though from a script
- Intolerance of other people's views

Summary

- Safeguarding is about protecting children, young people and vulnerable adults. It should centre on preventing harm from occurring in the first place, by placing gold standard safeguarding practices at the heart of education and healthcare environments, policies, procedures and staff recruitment.
- A transgender identity may not be a direct cause of harm, but should be seen as an indicator that wider safeguarding issues are likely to be present and will need identifying and addressing as appropriate and according to local safeguarding protocols.
- Children who are trans-identified should not be treated as exceptions to normal safeguarding practices - this is harmful, putting the child and their peers at risk.
- Safeguarding issues flagged by a transgender identity include:
 - The presence of other, possibly undiagnosed, physical and mental health issues or neurodevelopmental conditions (Autism, ADHD, depression, anxiety, eating disorders and self harming behaviours)
 - That a child or young person may have been the victim of bullying, abuse or harassment of a sexual or homophobic nature
 - That a child or young person may have been exposed to inappropriate actions, images or grooming online or in person
 - That a child or young person may have or intend to access illegally obtained medications online
 - That a child or young person may be causing themselves harm through the practice of breast binding or tucking of genitals
- Schools should work together with parents to ensure that all children are safeguarded, and to resolve any concerns in a collaborative and constructive way
- Keeping secrets for/with children is a safeguarding red-flag. No child should be promised absolute confidentiality.
- Social transition - changing name, pronouns, clothing, hairstyle and access to facilities - is not a neutral act and can have far reaching implications on the individual child, their family and their peers.
- Policies and procedures that may affect the safeguarding of a trans-identified young person or their peers include:
 - Allowing mixed sex provisions for sports, toilets, changing and overnight accommodation which impacts on other protected characteristics such as sex and religion or belief
 - LGBT Clubs and PSHE teaching which are unsupervised or promote the contested idea that a child or young person can be born on the wrong body or inadvertently promote behaviours which are a risk to health or safeguarding practices
 - The use of external providers for PSHE or other educational activities whose materials are not properly vetted against government guidance on extreme or damaging views

It is possible to offer kind, compassionate and considered support for any child or young person who has expressed distress around gendered expectations or their sense of identity, without putting either the child or their peers at unnecessary risk. Equality, Diversity and Inclusion are important principles within educational and wider contexts, but should never be pursued at the expense of well founded safeguarding frameworks.

Action Checklist: When a child says they are trans

Decision making should be undertaken as a multidisciplinary team, including the child, their parents or carers, teaching and pastoral support staff as well as mental health and/or social care professionals.



All concerns, discussions and decisions made, and the reasons for those decisions, should be recorded in writing. This will also help if/when responding to any complaints about the way a case has been handled by the school or college.

Keeping Children Safe in Education (2022)

The following issues should be looked at to ensure any actions do not result in a child being removed from safeguarding frameworks or having an unnecessary or harmful impact on the child concerned, or their peers:

1. A review of all possible safeguarding issues should be conducted and actions and decisions clearly documented and communicated to all parties involved, including the parents and where appropriate, the child concerned. A helpful safeguarding issues checklist is provided at the end of this document.
2. A review of all existing policies to ensure compliance with current guidance and legislation, including the Equality Act 2010 and Standards for School Premises
3. An Equality Impact Assessment should be carried out before making any decision on the use of single sex facilities or sports or changes to school policies
4. All members of staff involved in supporting the young person should be reminded of their safeguarding responsibilities and that absolute confidentiality should not be promised
5. Records should include:
 - a clear and comprehensive summary of the concern
 - details of how the concern was followed up and resolved, and
 - a note of any action taken, decisions reached and the outcome
6. Decisions should be regularly reviewed at agreed time intervals

Appendix A: Action Checklist for Trans-identified CYP

| | | | |
|-------------------|--|------------------------------|--|
| Name of child: | | Person completing checklist: | |
| Class/Year Group: | | Role: | |

| | |
|---|-----|
| Has a review of possible safeguarding issues relating to the child or young person been conducted? (See Appendix B: Safeguarding checklist for trans-identified CYP) | Y/N |
| Have any safeguarding issues been identified? Brief overview | Y/N |
| Have discussions of any safeguarding issues taken place with the parents? If no, why not? | Y/N |
| Are the child's parents aware of the trans identity? | Y/N |
| Are there any identified risks of including parents in discussions about their child? If yes, clarify here | Y/N |

| | |
|--|-----|
| <p>Has a children's services referral been made?</p> <p>Reasons for decision (for or against), name and date of referrer/al</p> | Y/N |
| <p>Has a review of all relevant policies been undertaken with regard to the Equality Act 2010, Standards for School Premises, and other Statutory Guidance?</p> <p>Which policies have been reviewed and/or revised?</p> | Y/N |
| <p>Has the trans-identified child or adolescent been granted permission to use opposite sex facilities and/or sports?</p> <p>If Yes, which facilities/sports? If No, what arrangements have been made?</p> | Y/N |
| <p>Has an Impact Assessment been conducted to ensure there is minimal impact on individuals with other protected characteristics?</p> <p>If not, give reasons</p> | Y/N |
| <p>Have staff working most closely with the child been given a copy of "Safeguarding Trans-Identified Children and Adolescents"?</p> | Y/N |
| <p>Have all staff been reminded that absolute confidentiality is a safeguarding red flag, and should not be promised to any child?</p> | Y/N |

Appendix B: Safeguarding Checklist for Trans-Identified CYP

| | | | |
|-------------------|--|------------------------------|--|
| Name of child: | | Person completing checklist: | |
| Class/Year Group: | | Role: | |

| | Concern (Y/N) | Nature of concern | Action identified | Person responsible for action |
|------------------------------|---------------|-------------------|-------------------|-------------------------------|
| Parental Involvement | Y/N | | | |
| Mental Health | Y/N | | | |
| Self-Harming behaviour | Y/N | | | |
| Neurodevelopmental condition | Y/N | | | |
| Trauma (incl. sexual) | Y/N | | | |
| Bullying | Y/N | | | |
| Binding or tucking | Y/N | | | |
| Online safety issues | Y/N | | | |
| Online medicines | Y/N | | | |
| Radicalisation | Y/N | | | |
| Other | Y/N | | | |

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