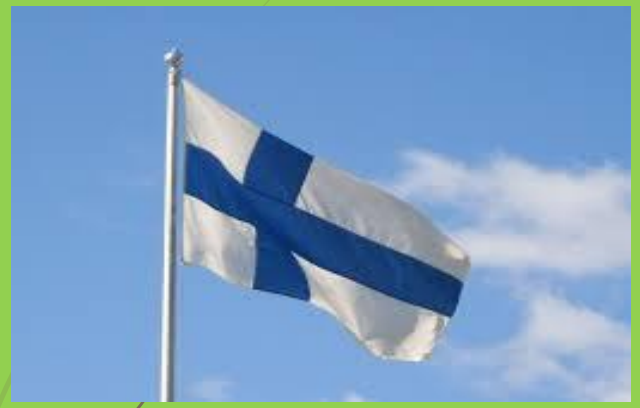
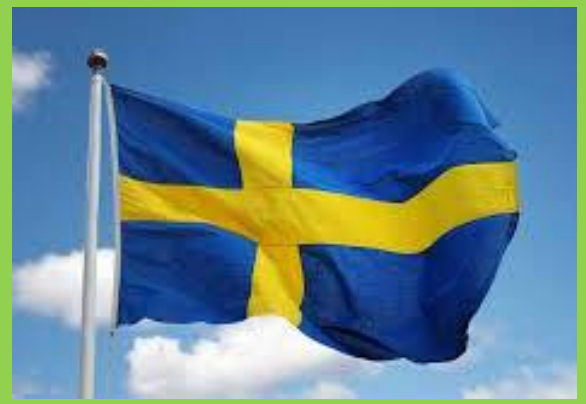
Gender Dysphoria Early Affirmation Treatment Warnings from Abroad





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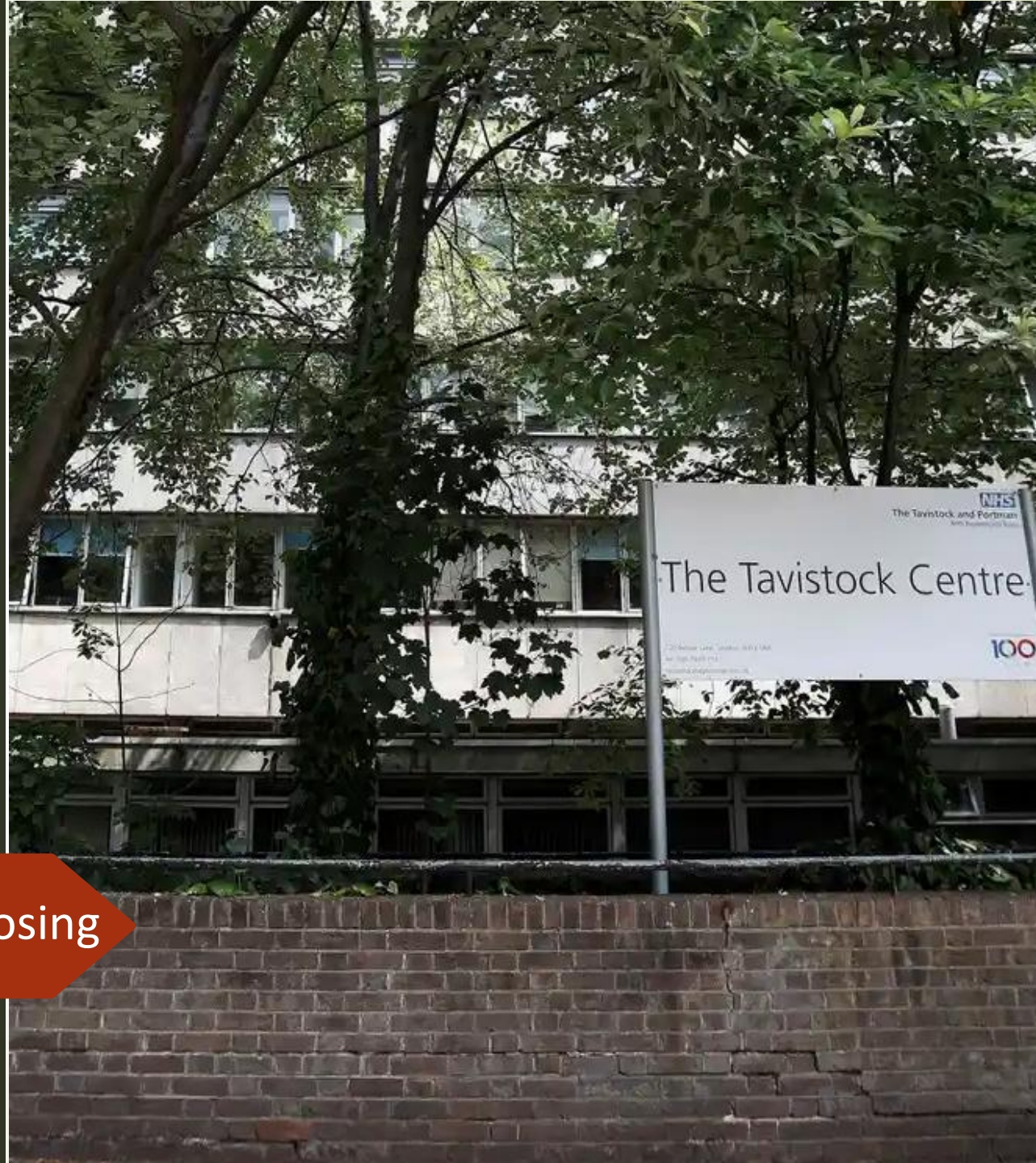
"I swear by Apollo the physician, and Aesculapius the surgeon, likewise Hygeia and Panacea, and call all the gods and goddesses to witness, that I will observe and keep this underwritten oath, to the utmost of my power and judgment. I will reverence my master who taught me the art."

— Hippocratic Oath

The UK's National Health Service will close the world's largest pediatric gender clinic, the Gender Identity Development Service in London (GIDS) often known as the Tavistock, after the NHS Trust which houses it. An independent review condemned the clinic as "not a safe or viable long-term option" because its interventions are based on poor evidence and its model of care leaves young people "at considerable risk" of poor mental health. The clinic must close by Spring 2023. It will be replaced by a new regional hospital-based service. Regional centers will typically be children's hospitals that also provide related services for mental health and autism, and have expertise in safeguarding, supporting looked-after children and children who have experienced trauma. Staff will therefore work across these related services "in order to embed the care of children and young people with gender-related distress within a broader child and adolescent health context."



The UK Tavistock Gender Identity Clinic will be closing

Click low for full articles:
https://www.bbc.com/news/uk-62335665
https://segm.org/UK_shuts-down-worlds-biggest-gender-clinic-for-kids
https://www.theguardian.com/society/2022/jul/28/tavistock-gender-identity-clinic-is-closing-what-happens-next

Finland recommends caution in early affirmative care

One Year Since Finland Broke with WPATH "Standards of Care"

Finland prioritizes psychotherapy over hormones and rejects surgeries for gender-dysphoric minors. A year ago, the Finnish Health Authority (PALKO/COHERE) deviated from WPATH's "Standards of Care 7," by issuing new guidelines that state that psychotherapy, rather than puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. This change occurred following a systematic evidence review, which found the body of evidence for pediatric transition inconclusive.

Click below for the full article:
https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors

PALVELUVALIKOIMA
Tjänsteutbudet | Choices in health care

Sweden recommends caution in early affirmative care

Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks. NBHW also concluded that the evidence for pediatric transition comes from studies where the population was markedly different from the cases presenting for care today. In addition, NBHW noted increasing reports of detransition and transition-related regret among youth who transitioned in recent years.

Click below for full articles:
https://segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth
https://genderclinicnews.substack.com/p/sweden-transitions-to-caution

New Swedish guidelines compared to WPATH guidelines

Comparison to WPATH Draft SOC8 Guidelines

There are several important differences between hormonal treatment eligibility criteria outlined by Sweden's NBHW and those put forth by WPATH in their recently released draft SOC 8 guidelines.

	Swedish National Board of Health and Welfare (NBHW), February 2022 update	World Professional Association for Transgender Health (WPATH), SOC8 draft
Management of gender dysphoria in youth	• First line of treatment is mental health support and exploratory psychological care. Hormonal interventions can be a last resort measure for some youth (see p.43, NBHW guidelines). • Hormonal interventions should be restricted to research settings. • Eligibility for hormonal treatment and ability to consent will be assessed by an interdisciplinary clinical team, with only a minority of patients expected to be treated hormonally. • Only "gender dysphoria" (DSM-5) will qualify for hormonal interventions. A transgender identity or "gender incongruence" without distress is not sufficient.	• There should be a general assumption to treat with hormones and surgeries. Mental health assessments are important but can also be abbreviated (see SOC8 draft "Assessment" section). • Hormonal interventions should be widely available in general medical practice. • Patient desire is the ultimate eligibility criterion. While ability to consent is important, inability to consent is not always a barrier to receiving "gender-affirming" interventions. • All forms of gender incongruence are eligible for interventions, and all interventions should be available to bring the body in congruence with identity.
Eligibility for hormonal interventions based on timing of gender dysphoria onset	• Prepubertal onset of gender dysphoria is required for eligibility for hormonal (GnRHa and cross-sex hormones) interventions. • An exception may be made for selected post-pubertal onset cases for pubertal suppression, but not for cross-sex hormones.	• The importance of long-lasting gender dysphoria is acknowledged, the timing of prepubertal vs post-pubertal onset is noted. • However, hormonal transition is allowed even for those with post-pubertal onset for eligibly.
Minimum age for puberty blockers (GnRH analogues)	Tanner Stage 3; suggested minimum age of 12.	Tanner Stage 2; no minimum age suggested.
Minimum age for cross-sex hormones (estrogen, testosterone)	Minimum age 16.	Minimum age 14.