SUICIDE & GENDER-DISTRESSED YOUTH:

QUICK REFERENCE GUIDE for POLICY MAKERS

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THE KEY QUESTION

Are puberty blockers and hormones necessary to prevent suicide in gender-distressed youth?

WHAT YOU'RE TOLD

- "Half of trans youth will attempt suicide without affirmation"
- "Puberty blockers save lives"
- "Denying treatment causes suicide"
- "The science is settled"

CLAIMS NOT BACKED BY EVIDENCE

CLAIM: "Half will attempt suicide"
REALITY:

- Comes from online survey of 859 self-selected adults (Trans Pathways, 2017)
- Asked about lifetime experiences, not deaths
- Not a national mortality study
- Among 15,000 UK gender clinic patients over 10 years: 4 suicides (0.03%)

CLAIM: "Puberty blockers prevent suicide"
REALITY:

- No controlled studies prove mental health benefit
- Cass Review (UK 2024): evidence of "very low certainty"
- Sweden, Finland: restricted use due to lack of evidence
- Some studies show worsening self-harm after blockers (Biggs, 2020)

CLAIM: "Without treatment, they'll die"
REALITY:

- Most suicidal distress driven by co-occurring conditions:
  - 75% have depression, anxiety, or other mental illness
  - 35% have moderate-severe autistic traits
  - Trauma, family conflict, eating disorders common
  - When these factors controlled for: gender distress not uniquely predictive of suicide (Finland registry, 2,083 patients)

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CLAIM: "Transition eliminates suicide risk"
REALITY:

- Swedish study: post-surgical patients had 19× higher suicide death rate than matched controls
- Recent US study: 12× higher attempt rate post-surgery even adjusting for confounders
- Long-term elevated risk persists after transition

WHY SCARE STATISTICS ARE MISLEADING

Most-cited figures come from:

- Self-selected online surveys
- No verification of identity or responses
- Mix adults and youth
- Mix ideation (thoughts) with attempts and deaths
- No control groups

POPULATION-BASED STUDIES TELL DIFFERENT STORY:

- Deaths rare (similar to other mental health presentations)
- Risk driven by comorbidities, not gender identity alone
- No evidence medical intervention reduces risk

WHAT INTERNATIONAL REVIEWS SAY

UK – Cass Review (2024)

- Most rigorous systematic review ever conducted
- Finding: "Remarkably weak evidence base"
- Recommendation: Puberty blockers only in research settings

Sweden – NBHW (2022)

- Finding: "Uncertain" whether benefits outweigh risks
- Recommendation: Hormones/surgery only in exceptional cases, research protocols

Finland (2020)

- Finding: Gender dysphoria doesn't independently predict suicide when comorbidities accounted for
- Recommendation: Psychotherapy as first-line treatment

WHAT GOOD CARE LOOKS LIKE

NOT:

- Fast-track medical pathway
- Single cause (gender) explanation
- "Affirm or they'll die" pressure

YES:

- Comprehensive mental health assessment
- Treat depression, trauma, autism appropriately
- Exploratory (not directive) therapy
- Family support where possible
- Time – most adolescent distress resolves
- Standard suicide prevention (safety planning, not hormones)

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RED FLAGS IN CURRENT PRACTICE

1. Speed: Youth medicated within weeks of first presentation
2. Lack of assessment: Mental health conditions untreated
3. Informed consent failure: Families not told about evidence gaps
4. No data collection: Jurisdictions don't track outcomes
5. Silencing dissent: Clinicians afraid to raise concerns

QUESTIONS YOU SHOULD ASK

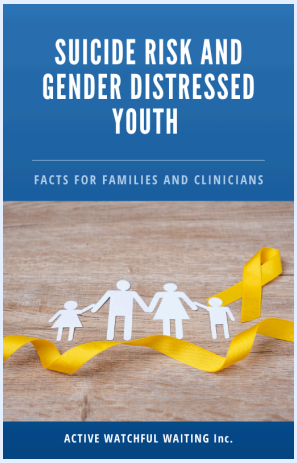
1. What proportion of youth at our gender clinic are assessed for autism, depression, trauma before medical intervention?
2. What evidence does our health department rely on for claim that transition prevents suicide?
3. What data does our jurisdictions collect on suicide rates among medically transitioned youth?
4. Has NHMRC and the health department *specifically* reviewed guidelines following Cass Review, Swedish/Finnish recommendations?
5. What support exists for families seeking exploratory therapy rather than immediate affirmation?

THREE THINGS TO REMEMBER

1. Distress is real – but driven by multiple factors, not just gender
2. Evidence is weak – systematic reviews find no proof of benefit
3. Risks are significant – infertility, bone density, unknown neurological effects

THE BOTTOM LINE

Young people experiencing gender distress deserve comprehensive mental health care that addresses all contributors to their suffering.
Claims that medical intervention is necessary to prevent suicide are not supported by high-quality evidence.
Policies based on exaggerated statistics and fear may harm rather than help vulnerable youth.



Evidence review with references:
aww.org.au/SuicideRisk
Questions: contact@aww.org.au