Sex And Gender Education (SAGE):
Access to Sexual Health Guidance Document for Sex, Gender and Sexuality Diverse People
July 2005

Clinical Guidelines

Identifying the Client Group

This document specifically looks at a humane practical, philosophical and clinical approach for Australasian healthcare providers offering services for sex, gender and sexuality diverse people. The client group can include people who are self-identified as intersexed, transsexual, transgender, androgynous, and sinandrogynous (without sex or gender identity ie neuter (O'Keefe 1999)). They may have varying forms of sexuality identity which may or may not necessarily be influenced by their sex and gender identity. This document is specific in that it deals primarily with people seeking to access sex, gender and sexuality health services that are often impeded because these client groups do not fit standard stereotype male and female body types or roles.

Historical Australian Approach

There are many kinds of clinicians that seek to meet the needs of sex and gender diverse people in order help this client group to attain and maintain sexual, physical psychological and social wellbeing. As with any other client group, care often commences with the frontline of the general medical practitioner, naturopath, or Chinese doctor, the first of these being the only ones recognised and funded by the Australian Medicare System (government funded).

Secondly, some people who are sex and gender diverse may need to access mental health services including psychiatrists, psychologists, and psychotherapists or counsellors, again only the first of these are funded by Medicare (government funded). Clients are also able to access some the above services either through private funding or through health insurance.

This client group may have also needed to seek the assistance of medical doctors and herbalists administering hormone-changing medication, again only the first of these are Medicare funded. Some of this client group may even seek surgical intervention to alter their bodies to represent characteristics of a different sex or to help them clarify their sex and gender presentation. Government policies as far as funding various surgical services have always been a grey area that can differ from state to state. Sometimes doctors have been able to get surgery funded by Medicare and sometimes they have not and there never has been a congruent policy on the funding of sex and gender altering surgery.

International standards

The Harry Benjamin Gender International Gender Dysphoria Association (HBIGDA www.hbigda.org) is clearly, at the time of the writing of this document, one of the world's leading resource pools of knowledge about the subject of sex and gender diverse people. Its remit started some 30 years ago by concerning itself with safe treatment for transsexual-identified individuals but since that time has broadened its remit to include transgender, androgynous and sinandrogynous groups. Its body is made up of some of the world's leading professionals in the field of sex and gender diversity, including general practitioners, surgeons, endocrinologists, psychiatrists, psychologists, psychotherapists, nurses, medical ethicists, social workers, lawyers, social historians and varying associated academics and clinicians, all dealing in varying aspects of sex and gender diversity.

HBIGDA publishes a document which is a guideline for the expected minimum level healthcare treatment of sex and gender diverse people called *The Standards of Care*. The exploration of this document clearly shows that it does not consider that sex and gender diversity is a form of mental disorder. The guidelines that it gives are clearly stated as to suggest that people seeking hormonal or surgical alteration of their bodies can be referred to an endocrinologist by professionals outside the psychiatric and psychological paradigms. This clearly indicates the HBIGDA position that it is inappropriate to railroad sex and gender diverse people towards psychiatric and psychological services if they prefer to take another route to transition. (Standards of Care Version 6 – www.hbigda.org/soc.cfm)

HBIGDA sees sex and gender diversity as a physical, mental and social phenomenon and does not label it as a mental illness. It acknowledges that people suffering from sex and gender dysphoria are people who are unhappy with their physical sexual characteristics and gender presentation and this produces high levels of anxiety that can at times lead to the danger of suicide (O'Keefe 1999, Ettner, 1999).

What HIBIGDA suggests is that an individual seeking hormonal and surgical intervention seeks psychotherapy before any physical transition is made; however, it is not obligatory that the patient must undergo such profiling. In reality what often happens is that no psychologically certified doctors may or will prescribe hormones and make referrals for surgery without subjecting the client to a forced psychological profiling. The HBIGDA has always been very clear on the issue that it recommends that any individual exploring sex and gender diverse physical, mental and social changes or transition may benefit from counselling but that should never be used as a Sword of Damacles to withhold treatment.

There have been cases, however, throughout the years where an individual who has made a sex and gender transition has changed their mind later in life. The common denominator that can clearly be identified between these cases is that they do seem to be people who have not entered in to an empathic therapeutic relationship with a psychiatrist, psychologist, or counsellor to fully discuss and explore the implications of their actions. There can also be people who have become involved with individuals, cults or religions, post-transition, who demonstrate opposition to the person's transition and a certain level of brainwashing has occurred, convincing the person that they did a sinful and wrongful thing by transitioning (www.gotquestions.org/sex-change.html).

The third category of these kinds of cases is when the clinician or client has plainly made an error of judgment (Campbell 1997, Colapinto 2000).

The second lot of standards to be considered when setting up clinics to service this client group are those which have over recent years developed out of the intersex community (www.isna.org and http://home.vicnet.net.au/~aissg). Whilst it has traditionally been the edict of doctors and surgeons to decide the physical direction of intersexed people's lives over the past 15 years, many intersexed people have stepped forward onto the world's stage and declared their dissatisfaction with such an authoritarian medical approach (Dreger 1998, 1999).

For those people who have an intersex physical presentation (anything up to 1% of the population), where their physical sex is other than typical male and female, it is now considered essential that they are consulted about any treatments they will undergo. It is no longer internationally acceptable for doctors or surgeons to interfere in that person's identity development against the client's wishes and without their consultation.

Australian porthole accesses for client care

In Australia sex and gender diverse people have historically accessed medical services through different portholes. They have been prescribed hormones by GPs, endocrinologists or psychiatrists, and these practitioners could have been the client's first port of call or through a referral from another professional.

Another group of people have bought hormones from street drug dealers and have been unable or afraid to approach professionals in healthcare. There is also a group of sex and gender diverse people who are currently buying hormones from abroad through the internet or by mail order and having them posted into Australia or are bringing them through customs, legally or illegally.

Since psychiatrists are the only government-funded mental health professionals through Medicare there has developed an erroneous belief in many quarters that psychiatrists are somehow necessary gatekeepers towards sex and gender transition. This thinking is an incorrect reflection of much of the rest of the world's philosophies around the subject of sex and gender diversity and transition, propagated by Australian psychiatrists themselves for purely business reasons.

In most of Europe and the US, referrals for hormones and surgery can be made by a wide variety of professionals including psychologists, psychotherapists, endocrinologists, social workers, and when people live in remote regions, even general practitioners. This is done specifically to avoid the stigmatisation of sex and gender diversity as a form of mental illness which it is not, nor is there any evidence to constitute that position.

Different people change their sex and gender characteristics for a variety of self-motivated reasons. Not all patients are the same and many may have social reasons for adopting different sex and gender identities other that they were registered at birth. Clients are no longer accepting purely clinical models that are trying to fit them into

pathological models of treatment or that clinicians have any right to determine a client's physical or mental identity. Any attempt by professionals or governments to railroad people into sex or gender identities that they feel are not right for them is nothing more than an act of violence, sexist and genderist oppression.

Sex, gender and sexuality dysphoria

Some people suffer from sex dysphoria, meaning that they are unhappy with their physical primary and secondary sex characteristics. Other people may suffer from gender dysphoria which means they are unhappy with the sex-associated social presentation in private or in public. There is a group of people who may suffer from both kinds of the previous dysphorias. Still further there are people who suffer from sexuality dysphoria, with a sense of unhappiness about how they relate to others sexually. None of these diagnoses constitutes a person having any kind of mental illness.

Whatever combination of the three dysphorias that a person may suffer from, resolution can sometimes be found through counselling or psychotherapy. For extreme cases of dysphoria, the patient may wish to alter the sex characteristics of their body through hormone therapy and surgical intervention to represent that of another sex and/or gender.

The importance of utilising a sexual health model as opposed to the psychopathology medical model

Sexual health is different things to different people and every Australian citizen and resident has a right to sexual health in compliance with the World Health Organisation's definition of health as physical, mental, social, and spiritual wellbeing. This includes all sex and gender diverse people regardless of their varying kinds of identities. Sex, gender and sexuality dysphoric people all require funding to help the sufferer to find resolution to their health crises and to attain and maintain sex, gender and sexuality wellbeing. Such a crisis needs to be assisted within the framework of positive sexual health criteria.

Full funding needs to be provided by the Australian government via Medicare, both at the national and state level to assist sex, gender, and sexuality diverse and dysphoric people with hormones, surgery and counselling if those are the person's treatments of choice. The care provided should also be carried out within the clinical context of good, positive sexual health and not an unnecessary pathologised model based on an unsubstantiated psychiatric pathologisation.

The average Australian person accesses good, positive sexual health models to assist them with birth control, genitourinary, gynecological, obstetric, abortion and reproductive services. People with sex, gender and sexuality dysphoria issues need to be treated in exactly the same way, and anything less is purely discrimination.

SAGEs guidelines for setting up clinics, projects or practices dealing with sex, gender and sexuality dyshoria issues.

1. All clinicians need to disclose to a client their qualifications, professional associations and their experience in dealing in the field of sex, gender and sexuality diversity and dysphoria.

2. The clinics need to adopt an approach of sex, gender and sexuality health promotion equivalent to the rest of the population's access to such services. For example: family planning, fertility treatment, men's and women's sexual health, genitourinary, obstetrics, services for sexually transmitted diseases, abortion and menopausal health services.

3. a) All clients need to have access to their medical records at all times upon request unless they are deemed non-compos mentis and under the jurisdiction of court-appointed treatment.

b) All clients should be made fully aware of the philosophy of the practitioner assisting them and no hidden agenda should be operated by clinicians or clinics. Those practitioners should also follow a path of continual professional development and remain updated with advances in the field of sex and gender diversity.

c) All clients should be made aware that the treatments available are not conditional and if at any time the treatment is inappropriate for that client, the clinician needs to make the client fully aware of alternative options.

d) All clients should be made aware that sex, gender and sexuality expression, diversity and dysphoria are not mental disorders and that there is no scientific evidence to support such a view.

e) All administration of hormones needs to be accompanied with some form of counselling by a professional in the psychiatry, psychology, psychotherapy or counselling professions who has experience in the field of sex, gender and sexuality diversity. Being a medical practitioner is an insufficient qualification to carry out such counselling.

f) All surgery to alter reproductive ability needs to be accompanied by the option of some form of counselling by a professional qualified in psychiatry, psychology, psychotherapy or counselling who has experience in the field of sex, gender and sexuality diversity. Being a medical practitioner is an insufficient qualification to carry out such counselling.

4. Clinicians should refer to other professionals when the range of treatments that the client may need is not within that practitioner's scope.

5. In cases where clients may suffer from a mental illness or disturbances other than sex, gender and sexuality issues, clinicians need to co-counsel through peer supervision in order to maintain professional objectivity. However, mental

illness should not preclude any sex and gender transition unless it is perceived as a short-term delusional state of mind. Even long-term schizophrenia or other co-morbidities should not necessarily preclude sex and gender transition.

6. No clinic should take financial commissions for professional referrals.

7. No patients of any age, sex or gender should be surgically operated on in order to alter their sex without their permission unless it is necessary in a life-saving emergency.

8. No patient should be administered hormones without their full consent and clarification that they understand they may have other options.

9. No client should have hormones withheld from them if such a prescription may be therapeutic to them.

10. The treatment offered to clients should be of a holistic nature in that clinics need to use an interdisciplinary approach, working closely and succinctly with other professionals.

11. It has been considered wise within medicine, psychology and social work for the medical intervention to alter physical sex characteristics to be accompanied by counselling. In some parts of the world, such psychological interventions becomes overbearing to the point of being oppressive and inhumane. In other parts of the world, medical intervention to alter sex characteristics is offered with absolutely no counselling at all. Both approaches can at times lead to clinical mistakes and clients need to be made aware of this.

12. To err on the side of caution, SAGE supports the ideas that such counselling should be offered with the administration of hormones and surgical interventions. Sage, however, also respects the right of the client to refuse such counselling if that is the client's wish and that should not stop a doctor administering those treatments.

13. SAGE respects the right of clinicians to refuse to treat clients they believe are not fully cognisant of their situations and options. A healthcare professional must follow the philosophy of ***Do No Harm*** and for each healthcare professional that may mean something different.

13. SAGE strongly advises that all clients seeking to alter their bodies through hormones and surgery use counselling services. It is, however, inappropriate that funding for other treatments should be withheld because clients choose not to undergo counselling.

14. Sage supports the concept developed by HBIGDA that a surgeon altering a person's reproductive organs to represent that of another sex is entitled to ask

for two letters of referral from specialists in the field of sex, gender and sexuality. Those specialists can either be psychiatrists, psychologists psychotherapists, counsellors, or social workers trained to doctorate level, with specialist knowledge and experience in the field of sex and gender diversity.

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