



**Changeling Aspects** In Affiliation with Agender (Aust.)

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To: Director  
Human Rights and Equal Opportunity Commission  
GPO BOX 5218  
Sydney,  
NSW, 2001

Dear Sir/Madam,

This is the hard copy of that I sent via e-mail as an attachment. I would again reiterate that if you have any questions on this submission, please do not hesitate to contact us.

Yours faithfully,

**Kathy Anne Noble**

**President Changeling Aspects.**

In affiliation with Agender (Aust)

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**A Written Submission on behalf of the Members of Changeling Aspects to The Human Rights And Equal Opportunities Commission, in the key areas of:**

**Legislation - Medical - Welfare - Future**

**Introduction**

Changeling Aspects is a support group for all members of the 'Trans' community, whatever their gender identity (or identities) and whatever stage in their 'transition' they have reached (if at all). However, all members must themselves be Trans-identified or 'questioning'.

We hope there will be meetings with HREOC where our members will be allowed to be present at the public debate. However if several members are unable to attend the meeting, we have put together this written submission highlighting issues that we have identified as the main areas of concern to Trans-people.

The following submission is intended to be positive and constructive in its nature, whilst highlighting some needs that should be considered and addressed.

The overall consensus at the Changeling Aspects meetings regarding health care provision for Trans-people was positive in nature.

Despite a notion that: while attending Clinics, Trans-people were treated with a lack of dignity, choice and inclusion, (a notion gained principally from anecdotal discussion via Online International Trans-Groups Forums), it is the opinion of Changeling Aspects that this is not 'generally' true in Australia.

In fact, it was expressed at our meeting, that the levels of commitment and professionalism of staff generally (in Australia) is high, and the main problems experienced were due to long waiting times and inflexible bureaucracies. This being said, some people at our meetings have had disquieting experiences regarding lack of dignity etc, and that despite a generally high standard within the Australian Medical fraternity, it was found that ignorance and prejudice still exists in Australia today.

We believe that this 'ignorance and prejudice' is mainly due to 'conjecture' being taught as 'fact' for decades now, this is why we feel strongly that there is an urgent need for the University Education System in Australia to be brought up-to-date with the latest knowledge of our condition and not teach 'speculation' as fact, as it does today.

This 'speculation' born in the early parts of the 1900s when psychology was in its infancy, has not had a major overhaul yet, and is sadly needing it. This redundant 'speculative-prognosis' is, we believe, responsible for personal experiences, which in turn are responsible for the perception of "significant dissatisfaction" and "Concerns about the standard of surgeons," and "Medical support in general", as stated repeatedly on Trans-Forums worldwide.

It should be the onus of the institution to dispel such fears!

## POINTS OF CONCERN INCLUDE:

### LEGISLATION

We have one Federal, six State, and two Territory Governments creating legislation concerning Trans-issues and none of them complement each other in any shape or form.

Is it any wonder that the Trans-community is lost in a morass of confusing legality? Add to this, the increased problems for those born abroad, and you begin to see the broader picture!

Those born abroad and not residing in; South-Australia, Victoria or Western Australia, have no access to recognition of their new phenotype–Gender via a Gender Recognition Certificate (GRC). This situation is further compounded by the fact that the Federal Government offer; Passports, Citizenship Certificate and Health Insurance Commission central records, all changed after Sex Reassignment Surgery (SRS) to their new phenotype–Gender, but that these forms of identity issued by the Australian Government are not considered ‘valid identity documents’ by some Government Depts. of other countries, e.g.: British Government –GRP.

Are we (those of us fortunate to be recognised in our new phenotype–Gender by the Country of birth) now fully recognised in Australia in our new phenotype–Gender? It appears to us that, we in Queensland, although recognised by our birth Country and by the Australian Federal Government for Passport, Citizenship Certificate and Health Insurance Commission after SRS, we are not recognised in Queensland, as they do not offer a GRC as full recognition of our new phenotype–Gender. This is after receiving an amended Birth Certificate (BC) from our birth Country!

Just how confusing can this get? Are we fully recognised as Male or Female throughout Australia, or only partially, by the Federal Government, but not by the State of Queensland, and other States and Territories that do not offer a GRC! It would appear that we are now more in limbo than we were prior to receiving an Amended BC from our birth Country!

The UK Gender Recognition Act 2004 (GRA) is predicated on “Non Surgery.

Question?

If the UK grants a person a GRC and an amended BC as female, but she still retains male genitalia, how would she be recognised in Australia?

- Would she be accepted?
- Would she have to undergo medical inspections?
- Would she be fully recognised in the UK, but rejected in Australia?

In recent years, the need\* (and demand by Officialdom) for validating, identity papers have increased dramatically around the world, this has simultaneously increased the need and urgency of having same said identity papers, ie: BCs, Passports, etc.

**Please note: this legislation tacks us on, alongside Deportees and Criminals.**

This is a quote from the Australian Passport Office.

**Quote:**

*87. An important example of when a document of identity may be issued when it is unnecessary or undesirable to issue a passport is when a person has lost or had stolen two or more passports and the Minister (or a delegate of the Minister) has decided to refuse to issue another passport. The person may be issued with a document of identity for international travel for a particular purpose. This enables the Government to balance the competing policy priorities in the International Covenant on Civil and Political Rights (1980 ATS 23 article 12) ensuring freedom of movement for a person while enabling the Minister (or delegate) to act where there are reasonable grounds to believe that person is*

*allowing others to use the passports for identity fraud or other criminal activity, or that the applicant is simply not adequately protecting his or her passport.*

**89. Other examples:**

*Australian citizens who request a document of identity instead of a passport; and Australian citizens who are TRANSGENDER, that is are living in the identity of a member of the opposite sex; and Australian citizens being repatriated or deported to Australia or extradited; and Australian citizens whose travel the Minister believes should be restricted.*

At this point I would like to state that we are the most over-officiated group of people in any country in the World. We have to change every conceivable piece of paper work in order to become recognised by Officialdom in our new phenotype–Gender. I would like to point out, that none of this applies to the Gay, Lesbian or Bi-Sexual Communities. They do not even have to declare themselves, and certainly do not have to change their Birth Certificate, Passport or Citizenship Certificate, or any of the other myriad items that Transsexuals are expected to alter to coincide with their new phenotype–Gender/Sex.

What is our true legal status in Australia?

It would also be helpful to know why, since Re-Kevin, are people forced to divorce or annul their marriage in order to be able to receive an amended BC in their new phenotype–Gender? The numbers involved in this area are small in comparison with the whole Trans-Community. They are moved by Government Departments from a situation of being married, to one of being a “same sex couple after SRS” which they are not if still legally married. Re-Kevin.

This is a case of a government trying to have both sides of the coin in operation!

Moving right along. Although a Court Order may be used to validate our identity, here it is a very expensive and time consuming matter, so we would sooner use the outcome of the New Zealand case to further our need\* for a GRC in those States and Territories that do not issue one to Trans-people who reside in that state or territory, but were born abroad. To date only South Australia and Victoria issue a GRC or the equivalent. I believe that West Australia may offer a Court Order.

As we are aware from our dealings with the UK under their Gender Recognition Act 2004, the issue of a GRC in the jurisdiction in which we now live and recognising us in our new phenotype–Gender would obviate the need for UK-registered doctors’ reports, as we could then apply via the UK “Overseas Track”

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\* - ‘need’ for GRC and other forms of identity, has been thanks to Governments around the world insisting on greater and greater levels of security and overwhelming ‘proof’ of who average citizens are. This makes sense, as said above, in light of the world events of the past decade, but this ‘need’ by the Governments of the world for tighter forms of proof, has revealed enormous errors, ambiguities, paradoxes, double-standards and conflicts between the various legislations of the Federal or National Governments of the world. Meanwhile, demands from these same World Governments for irrefutable evidence of proof of identity are so frustrating when their own laws confound and inhibit the process of delivering such proof.

These problems are not of the making of the Trans-community, but again by the inconsistency of various legislations of the Federal or National Governments of the world, many of which cannot even arrive at consistency of legislations among State Governments within those Federal countries.

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## **MEDICAL**

### **From a Primary Care perspective:**

This area is again hit or miss, as most Trans-people have no idea when they start on their journey, where to go, or who to approach! There is no National Register of Qualified\* Practitioners to help and it falls to Trans-support groups who offer support to show the way! (\* see-‘Future’ -page 7)

Those seeking treatment for gender-dysphoria often found their GP to be lacking in knowledge in how to proceed along the referral pathway, and many to be homophobic –(which, by the way, if it wasn’t so offensive, it would be amusing, since it is also in error, since we are not homosexuals....)

In many cases, this lack of professional knowledge resulted in cumulative delays for referral to a local psychiatrist before being referred yet again to the appropriate area. This initial referral is the all important one, but can take up to six months to receive an interview! How absurd? Does one wait for six months for a referral when one has a broken leg? I assure you that, delaying an urgent Trans-related referral can be more life threatening than a broken leg which left unattended for six months.

In some cases, people perceived reluctance by their GP to facilitate treatment on grounds of prejudice or because the GP was unwilling to participate in a shared care arrangement

There was also a perception that in some GP practices, staff were not adhering to the Privacy Act and that confidentiality was possibly being breached. Concerns were also raised about the new medical record database in regard to information about an individual’s gender issues being available to all personnel.

In regard to changing the gender signifiers on medical records, again, there seems to be a lack of knowledge on the procedures for this. However, where medical records had been changed accordingly, Trans-women found themselves being requested to attend for cervical smear testing. It has been the same for some Trans-men who have undergone hysterectomy; if the gender is listed as Male (for Trans-men), then GPs are sometimes reluctant to alter the patients record as it means that they would be removed off the list for smear tests when in fact there would still be a risk of cervical cancer.

In regard to the above, it was felt that this could cause undue embarrassment as well as being an unnecessary waste of precious resources. Accessing Sexual Health Care was also found to be problematic for Trans-people. Where clinics have segregated male and female areas, confusion arises as to where a Trans-man or Trans-woman should go –depending on their stage of transition.

Concern was also expressed about screening being cascaded down to GP practices. The current system allows for the individual to decide whether or not his / her GP should be made aware of any sexual health issues. If such a proposal is implemented, how will the status quo (re: confidentiality arrangements) be maintained?

### **Moving onto the Specialist Care Setting:**

Our main concern is the lack of medical support and knowledge of Transsexualism!

Whilst it is understood that Gender Specialist Clinics aim to be absolutely sure in providing the appropriate treatment for Transsexuals or gender-dysphoric individuals, the question does arise as to why treatment protocols differ from internationally recognised standards of care guidelines.

It could be argued that these international standards of care guidelines are just that, merely guidelines, and that a more rigid protocol should be in place to ensure appropriate treatment. However, some individuals have been informed, possibly quite appropriately, that the next stage of treatment cannot take place until the WPATH\* guidelines have been met. This apparent inconsistency, has also been noted in the way in which the clinic offers its treatment when compared to the private sector, especially so when it can be seen that the same medical professionals are working in both sectors.

It is felt that there should be more harmony between the public clinics and Private Sector in the approach to providing treatment for Transsexuals and gender-dysphoric individuals, and having access to surgical interventions. For example, using a public clinic, a Trans-man seeking bilateral mastectomy would require two referrals for surgery, whilst in the Private sector, he would only require one. In the private sector, one year of Real Life Experience (RLE) is deemed appropriate before a referral is made for gender reassignment surgery; the current public system insists on one or two years. In addition, it was suggested that it was unreasonable for a Trans-man having to do RLE when they have big breasts that are too big to bind. Instead surgery should be considered in these cases at a much earlier phase, perhaps within three months. Forcing them to have a male name and to try to present as male is inviting ridicule and harassment. However harmonising the two sectors does not mean that one should initiate “a levelling down to the lowest common denominator...” rather one should aim forward to best practice, namely the WPATH\* guidelines.

**\* WPATH - The World Professional Association for Transgender Health -( formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc.)**

Another point raised at the Changeling Aspects meeting concerned the scope of treatment available to Trans-individuals. Apart from offering an initial diagnosis confirming gender-dysphoria and / or Transsexualism, there is nothing offered to aid us in speech-therapy, Facial hair removal, and the entire multitude of other items we have to confront. One area of great concern is that of having access to Psychiatrists and Psychologists in the event of an emergency. There really is no fast track in place if an emergency does arise. We are usually told that we have to wait for an appointment, and in many instances this can prove to be too late –(fatal). We have a high suicide rate, attempted and achieved, so emergency support is a must! Cost is a very big consideration, especially if out of work or on a pension!

**NB:** It is considered that the vast majority of the Psychiatric and Psychological issues we face, are born of ignorance, superstition and prejudice against us, faced during our lifetime, and also instilled in us as very young children, and this is the origins of some suicidal self-loathing.

With education and the elimination of age old prejudices, these tragic symptoms can be eradicated.

There is a view that treatment for Trans-people should also include a more holistic approach with access to gender specialist counselling, and Laser/IPL/electrolysis depilation treatments. In addition, a greater choice of phalloplasty surgeons (there is only one established surgical team in Australia at present) and a wider range of surgical phalloplasty techniques should be made available to Trans-men.

There could be access into the system at different stages of the transition - e.g. post gender-reassignment surgery for speech-surgery, or post-operatively for medical issues outside the psychiatric domain - e.g. for remedial work for SRS conducted elsewhere, even if this has been undertaken on a private basis. It is worth bearing in mind how much an individual will have saved system resources, as we have to pay for SRS and every thing else, by entering into the system at a later stage and they should not be penalised for doing so.

In a similar vein, it was noted that people with gender-dysphoria who may not necessarily be transsexual are having difficulty in obtaining surgical procedures to help resolve their gender-dysphoria. Having gender-dysphoria does not necessarily mean one will be diagnosed as a Transsexual person requiring gender reassignment surgery. However, it may be appropriate for somebody who does not identify as transsexual to have surgical intervention such as breast augmentation, bilateral mastectomy or orchiectomy in order to alleviate their gender-dysphoria.

Attention was also drawn to the contentious issue of treating young Trans-people with hormone blockers, thus delaying the onset of what could be a traumatic and unwanted puberty. Re-Alex. Whilst it was recognised that clinicians are reluctant to initiate such treatment on young trans-individuals on the grounds that the experienced gender-dysphoria may be temporary and resolve at a later date, perhaps an evidence-based approach should be taken in offering such treatment, i.e.

consultation with other GICs e.g. in Holland\*, where there is an established protocol for this type of treatment with known outcomes of success.

\* <http://ai.eecs.umich.edu/people/conway/TS/Netherlands/Wrong%20Body.html>

\* <http://www.symposion.com/ijt/ijt0106.htm>

\* <http://www.onderzoekinformatie.nl/en/oi/nod/onderzoeker/PRS1236223/>

\* <http://www.onderzoekinformatie.nl/en/oi/humanageing/personalhealth/PRS1235467/>

For detailed information on Transsexualism - Please visit the “Technical Page” on our WebSite:

<http://www.changelingaspects.com/Main/Technical.htm>

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There is a perceived notion of “one size fits all” and an “all or nothing approach” in this regard. This can result in some Transgendered people seeking surgical intervention in the private sector and sometimes from surgeons abroad who have questionable expertise (Any resulting complications are sometimes left as is, as many surgeons will not correct the problems caused by others)

Many Transgender people who have surgery, especially SRS and are not proven to be Transsexual, are making a huge mistake, that cannot be rectified!

Again, better Education is required, not more obscure and conflicting legislation, and institutional policies, which “harms the many, to protect the few”.

We need to make significant positive changes now. Some put us in the ‘too hard basket’, and their sad policy is: “If in doubt, do nothing”

however, the truly wise choose: **If In Doubt: Do Something (Consciously).**

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This was invented by - Blaise Pascal (1623-1662)

From: **Reflections of Excellence.**

<http://www.fcg.com.au/reflections/stratex4.html>

In resolving a dilemma, Pascal also helped strategic management and our ability to make conscious decisions about an uncertain future. Like Pascal, organizations live with various unknowns.

They are, however, required to play the game they are in.

Using a modified version of Pascal's wager four options are open to us through the discipline of strategic analysis. These are:

1. **Do Something,**
2. **Do Nothing,**
3. **Do Something Consciously or**
4. **Do Nothing Consciously.**

A Strategic Wager analysis looks like this:

<b>Q1: Do Something</b> (Conscious Action) Low Risk - High Reward	<b>Q2: Do Anything</b> (Its all Good) High Risk - Uncertain Reward
<b>Q3: Do Nothing</b> (Conscious Inaction) Low Risk- No Reward	<b>Q4: Do Nothing</b> (Who Cares) High Risk - No Reward

In applying the Strategic Wager model, it is only the Quadrant 1 decisions: Doing Something Consciously - that provides both low risk and high rewards.

The other options rely, either on fate and good luck for success, or lead to us consciously doing nothing.

When the question is put this clearly, we can see why there is a potential shift in the standards required of the directors and officers of organizations.

Avoiding a decision is really just the abdication of decision-making responsibility, as might also be a consecutive series of decisions to Do Nothing.

By Doing Nothing, even consciously, we limit our exposure to new opportunities, which in turn would have created further options. This significantly limits future growth potential.

If Boards are not consciously applying their thinking to their key strategic management questions, this could in the future be seen as negligence.

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The above best illustrates and expresses concisely **our own belief**, “Do Something (Consciously)”, that management of these issues proactively, rather than reactively, best accomplishes the needed changes to Education and Human Rights as a whole.

Ideally, a truly patient-centred approach, for Transgendered people is what is required.

## **WELFARE**

Very little is known or done, or seen to be done in this area, and as we have an ageing population as a whole, globally, we surmise that we will be amongst that ageing population. This is also an area which has not been looked at carefully with respect to Transsexuals in Nursing homes etc.

Once again, if we had a long established education base, then these issues could be self-adjusting rather than requiring special legislation to accommodate what, at the time, seems to be special needs.

Long term studies of the issues now, would provide crucial data for future policies.

## **FUTURE**

We would like to see an addition to the Australian and New Zealand University Syllabus for all Medical Practitioners, most especially psychiatry, psychology and counselling. This could establish an official “Qualification” which currently does not exist. After this, a national register of “Qualified Practitioners” who have the knowledge, skills and expertise with Trans-issues, could be put in place!

Learning for all arms of the medical profession to be undertaken via Universities and on-going learning for GPs, Psychiatrists, Psychologists, Endocrinologists and Surgeons as the times demand! Also vital to the whole is a teaching course for nursing staff and social counsellors of all kinds.

We would like to see Homophobia and Transphobia eradicated, or reduced by the process of learning about the Trans-community and not be continually told “You are in the too hard basket, so we are going to do nothing.”

We hold great fears for the future of the young ones coming through, and for those already suffering through lack of knowledge and skills from the medical profession. This also includes some of the Intersex people of Australia who were misdiagnosed or mis-reassigned at birth or soon afterward. They also have to deal with the bewildering complexities of legislation surrounding the status of their “Gender.”

It has been suggested that due to ubiquitous chemical pollution (Global EDCs), the incidence of Intersex and Transsexualism is on the increase, so we feel it would be prudent to start the ball rolling for better research, education and legislation now.

## **SYNOPSIS OF: POINTS OF CONCERN**

The provision of health care to Trans-people has certainly improved leaps and bounds over the past decade, and the understanding of the condition of Transsexualism and of gender-dysphoria has become more widespread and understood. This does not mean, however, that service providers should rest on their laurels and not strive in continuing to improve health care for Trans-people.

In the current political climate, there is a real fear that Trans-people will once again become marginalised and their access to health care provision, instead of being enhanced further, will be cut back in the face of prioritising needs.

In regard to Primary Health Care, the issues raised above can be addressed through education of GPs and staff in all quarters. Trans-people often encounter, prejudice and ignorance of gender issues within the system. A proactive culture of respect, understanding and awareness of the issues Trans-people face when accessing health care should be fostered. Perhaps such a proactive approach would include identifying to staff their legal obligations and duty of care in providing non-discriminatory care to all, Trans-people included. Consultation with Trans-people and the implementation of ideas discussed will go a long way to alleviating these concerns.

Adopting a national framework approach rather than a State by State approach would be beneficial for Trans-people nationally.

It is hoped this submission from the members of Changeling Aspects will provide the panel members with a useful summary of the experiences faced by a cross section of Trans-people in Australia

## **SUMMATION**

We fully appreciate that what we are asking for is huge, but it is, with respect, time that these issues were addressed!

We are a minority, but are Human Beings and deserve respect and rights as accorded to all Human Beings.

Currently, we do not have perceived rights and are seemingly not thought of as being Human.

We suffer enormous stress and difficulties in coming to terms with our Transsexualism and the major impact that it has on our lives.

We are marginalised through no fault of our own, but because of a biological quirk of nature.

If given the opportunity to show what we can do, you will find we are a useful adjunct to Society as a whole. You will find us throughout society, doing worthwhile work, if allowed to.

We wish to thank you for your time, and if you would wish to discuss any of the items raised, we are only too happy to assist.

**Love and Peace,**

**Kathy Anne Noble,**

**President of Changeling Aspects**

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