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## **Standing Committee on Health**

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**EVIDENCE**

**Thursday, February 28, 2019**

**Chair**

**Mr. Bill Casey**



## Standing Committee on Health

Thursday, February 28, 2019

• (1535)

[English]

**The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)):**  
We'll call our meeting to order. I welcome everybody to meeting 137 of the Standing Committee on Health.

I want to report to the members that we tabled our rare disease report today, and I know that a lot of people have already asked for it, so they're looking for our wise words. I want to congratulate the analysts and clerk for helping us put together a really good report.

Also, our travel to the west was approved today at liaison committee, but it still has to go through the House. We should be able to go ahead on that.

I want to welcome our guests today. This is our very first meeting on our LGBTQ2 health study. We're looking forward to it. I want you to know that it perhaps will be the most extensive study we've done. We plan on having a lot of meetings and hearing from a lot of witnesses. It's not the most expensive. The pharmacare study would be the most expensive. It was two years long.

We're all interested to hear your testimony and to hear where this going to go.

Today we have with us, on behalf of Rainbow Health Ontario, Devon MacFarlane, director; from the University of Toronto, Dr. Lori Ross, associate professor, Dalla Lana School of Public Health; from Egale Canada Human Rights Trust, Richard Matern, director of research and policy; and from Toronto Pflag, Giselle Bloch.

Welcome.

Each of you has 10 minutes for an opening statement. I'll signal to you if you hit 10 minutes, but try to keep it within 10 minutes if you can, because I know everybody is anxious to ask questions.

We're going to start with Mr. MacFarlane.

**Mr. Devon MacFarlane (Director, Rainbow Health Ontario):**  
Thank you, Mr. Chair, and members of the standing committee, for having us come to speak today.

My name is Devon MacFarlane and I work as the director for Rainbow Health Ontario, which is a program of Sherbourne Health. Rainbow Health Ontario creates opportunities for the health care system to better serve LGBT2SQ people and communities. We do this through supporting clinical practice and organizational change, public policy work, catalyzing research and knowledge translation. Rainbow Health Ontario is unique in Canada.

We at Sherbourne are very excited that you've undertaken this study of LGBT2SQ health in Canada, and I am so pleased to be here at your opening meeting.

Today, I'll provide a broad overview of LGBT2SQ health and set the stage for my fellow speakers. I'll touch on the size and diversity of LGBT2SQ communities, health disparities facing our communities, causes and contributing factors, impacts on individuals and society, and actions that could contribute to positive change. We will submit an evidence-based brief that expands on these remarks. For brevity, I'll be using LGBT as an acronym.

Let me begin by painting that broad picture. The image that often comes to mind when we think about LGBT communities is of young, white, fit gay men at pride events. However, our communities are very diverse. People live in big cities, small towns, on and off reserves and up north. Our communities include small children through to people in their nineties and beyond. We're from all cultures, ethnicities, races and faiths. Our communities include francophones, people with a broad range of mother tongues, and newcomers, including refugees. Our communities also include people who are homeless, poor, middle income, and high income.

Rainbow Health Ontario uses an estimate that about 7.3% of the population identifies as lesbian, gay or bi and 0.6% identifies as trans. In Canada, that translates to about 2.9 million people. There are yet more people who may not have that identity but engage in same-sex behaviours.

The best available health data points to clear disparities for LGBT people, some of which are not obvious. We see higher rates of cancer and problematic substance use, and among lesbians and bi women, higher rates of chronic diseases, such as cardiovascular diseases, asthma and arthritis. There also seems to be an earlier onset of some chronic conditions. Not surprisingly, given the increased prevalence, we also see precursors, such as higher rates of cancer-related risk behaviours. There are also higher rates of dental problems, and of pregnancy involvement among LGBT youth. Then, of course, there are STIs, HIV and mental health and suicide, which are what most people tend to think about around health in our communities.

In short, in any area of health and health care, including palliative care, pharmacare and the opioid crisis, there are likely issues for our communities. However, nothing inherent to our identities causes these disparities. To consider possible policy interventions, we first need to look at contributing factors.

LGBT people experience familial and societal rejection, higher rates of childhood sexual and physical abuse, violence, stigma, prejudice and discrimination. Many members of our communities also experience other forms of discrimination, such as racism, which add to their stress. If you've been openly discriminated against by your family and others, attacked for who you are or experienced discrimination in employment, it's no wonder that you might be dealing with depression, anxiety, PTSD and suicidality. Many cope through substance use, including smoking, as self-medication.

Of course, we have lots of areas where there's also resiliency, but in this case, we need to be looking at disparities. Trans youth in Canada, for instance, who don't have family support, and have experienced other forms of discrimination, have a 72% chance of making a suicide attempt in a 12-month period. Youth with strong family support, however, and who experience no other forms of discrimination, have just a 7% chance. Across the lifespan, 45% of transpeople, almost half, have made at least one suicide attempt.

- (1540)

Experiences in accessing health and social care and barriers to clinically and culturally competent care contribute to health disparities. Canada's health care workforce is vast. Most providers have not had any content on LGBT health while in schools. While most providers are well intended, they don't know clinically what to do and what not to do. This results in many people not being out to their health care providers or avoiding care altogether due to previous experiences and fears of discrimination.

In particular, lesbians, bi and transpeople have been found to have a range of unmet health needs. Transpeople have specific concerns, due in part to wait-lists, due to not all required interventions being funded and due to an extremely limited number of providers and agencies that have the knowledge, skills and desire to serve them.

There are also exponential increases in the number of transpeople seeking care. For pubertal trans kids, access to puberty-blocking medications is particularly time sensitive, yet the clinics who serve them are struggling to keep up with the demand and often can't see them for many months while changes are happening in these young people's bodies.

LGBT seniors face specific needs and issues, including in end-of-life care. They are more likely to be aging alone and are less likely to have family or friends who can provide care they may need, and they may struggle to identify a substitute decision-maker. Mistrust in the health care system is significant. LGBT seniors grew up in an era when being gay was a criminal offence, as well as being considered a mental illness. Some were institutionalized and subjected to electroshock therapy.

Although many younger seniors have been out their entire lives, they are afraid that they'll have to go back in the closet to access care. A study found that one-third of LGBT home care users were afraid that their home care providers wouldn't touch them if their sexual orientation or gender identity were known.

Health disparities and impacts of discrimination lead to worse outcomes at the level of the individual as well as Canadian society. This includes outcomes in terms of life expectancy, disability-adjusted life years, or DALYs, loss of economic contributions and avoidable health care costs.

For instance, a U.S. study found a difference of 12 years of life expectancy for LGB people living in welcoming and affirming regions versus hostile regions of the country. Both human and economic costs are huge. When we look at disability-adjusted life years for LGBT Ontarians, over a thousand extra years are lost every year just due to mental health and three specific forms of cancer. In Ontario alone, this translates to an annual loss of GDP of between \$11 million and \$33 million.

While the health disparities and barriers to competent care are significant, action can be taken to create positive change, both directly to health care and also in relation to determinants of health. For determinants of health, action could include—and we would recommend that action be taken on—increasing support for families to enable them to better support their LGBT loved ones; addressing hate crimes, violence and discrimination that target LGBT populations; and addressing LGBT issues in housing, homelessness and poverty reduction.

Specifically in health care, action could be taken in any federally led health programs, services and initiatives, ensuring that LGBT issues are addressed; making provision for LGBT health in transfer funding and agreements and encouraging provinces and territories to meaningfully address LGBT health; generating commitments and mobilizing health care organizations to address LGBT health care disparities and barriers to care, and ensuring equitable access to care that is both clinically and culturally competent; skills development for health care providers, recognizing that we have a very large health care workforce, most of whom could be more effective given the opportunity; funding for LGBT-specific chronic disease prevention initiatives, including robust evaluation and knowledge translation; and, ensuring that transpeople across the country can get access to needed transition-related care in a timely way.

• (1545)

In research and monitoring, we would recommend building on the new StatsCan unit and Canadian Institute for Health Information's work on equity measures, ensuring robust data collection and reporting, including for health care administrative data; monitoring progress on LGBT health, and health outcomes, including disability-adjusted life years and potential years of life lost and the associated economics costs; significantly increasing funding for LGBT health research, with a focus on population health, improving clinical care, improving health systems, and the impact of interventions. Within this, there need to be significant focuses on lesbian, bi, trans, and two spirit people, and especially on parts of our population who are racialized, newcomers, francophones, and people living outside of major urban centres or who are experiencing poverty.

In closing, we at Sherbourne are pleased that you are embarking on this study. It is fantastic. The study and any actions taken could have far-reaching impacts. Addressing health disparities for LGBT people is one of the next major frontiers in our work to build an equal and just society where all can healthily participate and contribute.

By building on our human rights successes, Canada could be poised to be a world leader on LGBT health.

Thank you for your attention and for your work on this front.

**The Chair:** Thanks very much.

Now we'll go to Dr. Ross.

**Dr. Lori E. Ross (Associate Professor, Dalla Lana School of Public Health, University of Toronto):** Mr. Chair and members of the standing committee, I am delighted to have this opportunity to speak to you in this first meeting of your historic study on LGBTQ2 health.

My name is Lori Ross, and I'm an associate professor in the Dalla Lana School of Public Health at the University of Toronto. I've been conducting research on LGBTQ2 health in Canada for the last 15 years, and in the time I have with you today, I'd like to draw your attention to two key issues for consideration in this study.

The first is that there is vast diversity, and in turn there are particular vulnerabilities within subgroups of the larger LGBTQ2 community, which we must attend to in order to meaningfully impact the community's health. The second issue is that enhancements to our current data collection mechanisms are required in order to more fully characterize and ultimately monitor improvements in LGBTQ2 health in Canada.

In making my first point, I'll particularly be drawing your attention to what we know about mental health outcomes within the LGBTQ2 community, given that this is an area where we see especially marked disparities, but please note that the within community vulnerabilities I am describing also pertain to many of the other health outcomes that Devon has drawn your attention to in his presentation.

Our first opportunity to examine LGBTQ2 mental health in Canada using population-based data started in 2003 when a question about sexual identity was first added to the Canadian community health survey, or CCHS. Analysis of these early data revealed that those who identified as lesbian, gay or bisexual were significantly more likely than heterosexuals to report a lifetime mood or anxiety disorder as well as lifetime suicidal ideation.

Subsequent analyses of more recent cycles of the CCHS continue to replicate these findings, showing no substantial decrease in the magnitude of the disparities, which are striking. In the 2003 data, lesbians and gay men were approximately three and a half to four times more likely than heterosexuals to report lifetime suicidal ideation, while bisexual women and men were approximately six times more likely.

This brings me to the first subgroup within the LGBTQ2S community that I would like to draw your attention to: bisexual people. Many are surprised to learn that bisexual people make up the largest sexual minority group, outnumbering gay men and lesbians. Often people are also surprised to learn that bisexual people report the poorest health outcomes of any sexual orientation group. That is, across a wide range of health outcomes, bisexual people fare more poorly than not only heterosexual people but also lesbian and gay people. Research suggests that these poor outcomes are likely attributable to the specific forms of discrimination faced by bisexual people as well as the pervasive invisibility of bisexuality, which in turn leads to a lack of social support. My team's work suggests that bisexual youth may be particularly at risk for poor mental health outcomes, with a recent survey of more than 400 bisexual people in Ontario finding that nearly 30% of bisexual youth reported past year suicidal ideation.

You may have noted that I have so far spoken only to sexual orientation. This is because until very recently—so recently, in fact, that the data are not yet available—we have not had access to any population-based data regarding the health of transgender people in Canada given the lack of a question on gender identity in our population-based surveys.

To understand the health of transpeople in Canada, we need to turn instead to the rigorous community-based research that's been conducted on this topic, particularly the Trans PULSE study, which was conducted in Ontario between 2009 and 2010 and currently is in development for a nationwide version to be launched in the coming months. Trans PULSE data estimated the prevalence of depression among transpeople in Ontario to be more than 60%. Thirty-six per cent of transpeople reported suicidal thoughts in the past year, and 10% reported a past year suicide attempt. Consistent with what Devon has told you about the impact of discrimination, those people reporting high levels of transphobia and low levels of social support were most at risk for these outcomes. These findings are echoed in a recent survey of more than 900 Canadian transgender youth, in which a shocking 65% reported past year suicidality.

The good news is that we have opportunities to change these statistics. Analysis of Trans PULSE data suggests that, by increasing levels of parental support and reducing levels of societal transphobia, it would be possible to dramatically decrease rates of suicidal ideation and attempt. Given this, attention not only to transpeople's health outcomes and health care experiences, which indeed is sorely needed, but also to the social conditions that produce these health outcomes, is critical.

I would next like to turn your attention to mental health among two-spirit and other indigenous LGBTQ2 people in Canada. Unfortunately, this is another area where data are lacking, again due to gaps in our collection of data related to sexual orientation and gender identity in surveys of indigenous health. Here, too, what we know comes largely from community-based research conducted in partnership with two-spirit people to assess health concerns and outcomes. This reveals high rates of depression, anxiety, drug use and suicidality. Qualitative research has highlighted the historical and ongoing impacts of colonization on two-spirit health, noting the critically important roles of intergenerational trauma and loss of language and culture. As for other indigenous people, interventions

to redress these and other impacts of colonization must be at the forefront in order to meaningfully address two-spirit health in Canada.

• (1550)

In a similar vein, we so far know very little about the health of LGBTQ2 people who are members of other racialized groups in Canada, given that the sample sizes of population-based surveys have been too small to permit these types of intersectional analyses. Data are also lacking regarding the health of LGBTQ2 francophones and linguistic minorities, but through the lens of the minority stress framework, we would anticipate that discrimination and associated barriers to accessing health care may produce important disparities for these communities as well.

Finally, before turning to a brief discussion of data gaps and possibilities, I would like to highlight the importance of considering socio-economic issues as they impact the health of LGBTQ2 people. The available Canadian data indicate that there are important income disparities associated with sexual orientation and gender identity and that these disparities contribute to the health problems that we observe in our communities.

For example, in our research with bisexual people in Ontario, we found that over 25% in our sample were living below the low-income cut-off, and those living below the cut-off reported significantly higher levels of depression and post-traumatic stress disorder than those living above it. Given the elevated rates of homelessness and evidence of employment discrimination associated with sexual orientation and gender identity in Canada, policy interventions to address these and other social determinants of health for LGBTQ2 people will be an important mechanism for addressing the health disparities we are discussing today.

I would like to close with a brief discussion of the limitations and possibilities regarding data about sexual orientation and gender identity in Canada.

For many years, researchers and community advocates have been struggling with the lack of adequate data necessary to properly characterize health disparities for the LGBTQ2 community. Although the sexual identity question on the CCHS has been essential, the lack of data on gender identity as well as other important dimensions of sexual orientation such as sexual behaviour and sexual attraction has greatly hindered our work. The fact that the sexual identity question has been asked only of respondents aged 18 to 59 also limits our knowledge of youth and older adults, both groups with particular vulnerabilities.

As a result of these limitations, we have largely needed to turn to U.S. population-based datasets or seek funding to develop community-based research projects to address the necessary data gaps.

Statistics Canada's newly established Centre for Gender, Diversity and Inclusion Statistics offers the opportunity for Canada to become an international leader in this area through enhancements and additions to the questions currently asked on StatsCan surveys; the addition of relevant questions to surveys where they are not currently included, such as in the Canadian income survey; support to other levels of government in collecting appropriate sexual orientation and gender identity data; and development of innovations to ensure that the resulting data sets are sufficient to allow for robust analysis of important subgroups within the LGBTQ2 community.

This current study on LGBTQ2 health perhaps offers a natural opportunity to bring together the expertise of the new centre with Canada's ample academic and community expertise in LGBTQ2 health to maximize our opportunities for excellence in this domain.

At the same time, it's important to foster funding mechanisms to support community-driven research in LGBTQ2 health, which will inevitably continue to be essential in identifying emerging areas of concern. Historically, much of the research conducted in the area of LGBTQ2 health has been funded through HIV-related mechanisms. While HIV is certainly a health issue of concern to the LGBTQ2 community, as you are hearing today, our health needs extend well beyond this, and the HIV focus has been limiting.

Further, at present there is no explicit home for LGBTQ2 health research within the Canadian Institutes of Health Research; that is, there is no institute that explicitly includes LGBTQ2 health within its mandate. While the Institute of Gender and Health does include the health of gender-diverse people in its mandate and has funded important research on LGBTQ2 health, not having sexual orientation named in the institute's mandate means that we rely on supportive review committees to consider this type of work is within the institute's purview. Recognizing sexual orientation and gender identity within the mandate of the Institute of Gender and Health or within a variety of relevant institutes, together with priority funding announcements to address specific knowledge gaps, would serve to build a robust evidence base upon which to ground policy and practice interventions to address health disparities for LGBTQ2 Canadians.

• (1555)

In summary, despite major human rights advances and associated improvements in social conditions for many LGBTQ2 Canadians, significant health disparities persist. However, this first federal study on LGBTQ2 health and the new Statistics Canada Centre for Gender, Diversity and Inclusion Statistics make this a historic moment for understanding and ultimately addressing LGBTQ2 health in Canada. I greatly appreciate the opportunity to be a part of the conversation.

Thank you.

**The Chair:** Thank you for your contribution.

Now we'll go to Mr. Matern from Egale.

**Mr. Richard Matern (Director of Research and Policy, Egale Canada Human Rights Trust):** Dear Chair and members of the Standing Committee, Egale is very pleased that you have undertaken this study on LGBTQ2S health in Canada. Thank you for giving us the opportunity to be here at your opening meeting.

My name is Richard Matern. I'm the director of research and policy at Egale. As Canada's only national LGBTQ2S organization, Egale works to improve the lives of our communities in Canada through informing public policy, inspiring cultural change and promoting human rights and inclusion.

As Lori talked about, and in spite of the many legal advances we've made, significant disparities in equality remain, especially in the health sector. Not only does the LGBTQ2S community in Canada face barriers and stigma within the health system itself, but it also faces significant challenges in social determinants that significantly impact health, such as income and food security, employment status and work conditions, as well as connections to social networks and community. This is especially pertinent for members of our community who are racialized, living with a disability or have other multiple marginalized identities.

Within the health care system, as Devon talked about, people routinely face barriers in accessing appropriate care, rooted in insufficient training for health professionals on cultural competence and population-specific health considerations. This also includes limited and inconsistent coverage for therapeutics and medically necessary surgeries associated with gender transitioning.

Additionally, I would add that intersex people continue to be subjected to non-consensual surgeries, stigmatization and withholding of information, despite these practices being contrary to international human rights law. It is estimated that 30% to 80% of intersex children undergo more than one surgery, and some have as many as five surgeries. Section 268 of the Criminal Code continues to allow non-consensual surgery by medical practitioners to alter the bodies of infants and children whom they perceive to be ambiguous.

Outside of the health care system, the social determinants of health act in complex and compounding ways to negatively impact LGBTQ2S people. Perpetual encounters with homo-, bi- and transphobia at school, in the workplace and elsewhere contribute to isolation and chronic stresses that can directly impact educational achievement, career progression and income levels. This added stress can lower mental health status and include a heightened risk of developing depression, anxiety, substance use and suicidality.

From my colleagues, you've heard a lot of stats around mental health and suicidality in our community. What I'll add is what we found in our Egale Youth Outreach Centre, which is a drop-in centre that we've opened for homeless and under-housed LGBTQI2S youth in Toronto, where we see first-hand the impacts of some of these larger systemic forces on the youth in our community. For instance, since we opened the centre in 2016, we've seen thousands of visits each year averaging over 100 unique client visits per month, with new intakes increasing by 127% and therapeutic interventions increasing by 417%. Last year, over half the youth visiting the centre were either lesbian or gay, while one third were transgender and/or non-binary.

The top three presenting concerns among youth were mental health, employment and family relationship issues. A significant number also expressed that they were at some level of risk for suicidality. Other concerns included housing, social isolation and substance use which, while not as common as the aforementioned specific issues, frequently arise as intersecting and ensuing challenges that staff are called to assist with from month to month.

Many of the youth are homeless or under-housed. They don't feel safe in the present shelter system. Many struggle to meet basic needs. For example, EYO's food program, in which 15 to 30 participants eat per day and rely on for their food per day, has been a crucial service that has required additional resources and partnerships in order to address the food insecurity faced by participants driven by poverty and low incomes.

Seniors in our community are also impacted. What we hear from the seniors we work with is that many in our community are isolated. They lack the familial and social supports of their heterosexual or cisgender counterparts and also in many cases have a lack of access to employer-triggered pension plans due to a lifetime of stigma and discrimination in the workforce.

While there is limited Canadian data available on the specific needs faced by LGBTQI2S seniors, as Lori has talked about, U.S. data quantifies the anecdotal evidence that we hear through our National Seniors Advisory Council. One survey demonstrated that 42% of LGBT older people are very or extremely concerned that they will outlive the money they have saved for retirement, as compared to 25% of non-LGBT older people. U.S. data also demonstrates that disability is overrepresented among LGBT older persons, with nearly half of a large U.S. sample of LGBT older adults reporting a disability.

• (1600)

As was mentioned by Devon, LGBTQI2S seniors also fear going into assisted living centres and long-term care facilities. They often feel they must hide their identities and partners to stay safe from abuse and discrimination.

In a national consultation conducted by Egale and its National Seniors Advisory Council, it was shown that the top issue with the largest perceived impact on seniors in our community was the fear of being re-closeted in residential care. Particularly in cases of dementia and/or Alzheimer's disease, many seniors in our community worry whether their identities will be honoured and respected as their consent and autonomy are brought into question.

As you have heard, the study presents a crucial opportunity for the federal government to address the health challenges that remain for LGBTQI2S people to ensure adequate and appropriate actions are taken to establish new priorities, reprioritize key needs, recognize the gaps in services and provide solutions for the improvement of life for members in our community.

In order to address our concerns in this area, we make the following recommendations:

First, conduct large-scale consultations with intersex people living in Canada as an initial step towards reforming subsection 268(3) of Canada's Criminal Code, which continues to allow non-consensual surgery by medical practitioners.

Two, ensure that Bill C-81, the accessible Canada act, incorporates measures to address barriers that disproportionately impact members of the LGBTQI2S community who are living with disabilities, including ensuring safe spaces in health care settings. This includes requiring health care colleges to have frameworks in place to protect service users from our community and mandatory competency training in LGBTQI2S issues.

Incorporate measures that support LGBTQI2S individuals living with a mental illness and in the criminal justice system, including the development of a national harm reduction strategy with specific funding allocated to address the mental health and addiction needs of LGBTQI2S individuals.

Ensure that the national food policy includes a plan to address food security among LGBTQI2S people, including those living in poverty as well as those living in indigenous and isolated northern communities.

Incorporate within the new health accord measures to assess and integrate health care needs that are faced by the LGBTQI2S community, including allocating specific funding towards services that attend to the mental health needs of diverse LGBTQI2S people across the country.

We would add, end discriminatory practices related to blood donation for men who have sex with men, and transpeople.

Also, develop a national gender-affirming health care strategy to ensure comprehensive health care for trans and gender-diverse communities that is physically and economically accessible and addresses their wide-ranging health care needs.

In line with the Canadian guidelines for sexual health education, implement consistent sexual and reproductive health education across all provinces and territories that is comprehensive and inclusive of LGBTQI2S health issues and experiences and is geared for adolescent and youth development.



Provide for accessible and affordable contraceptives, immunization plans and preventative sexual health care, including PrEP, pre-exposure prophylaxis, and PEP, post-exposure prophylaxis, within sexual health coverage across Canada.

Finally, recognize LGBTQI2S family planning and diverse family structures by training health care professionals, including IVF clinics, on inclusive patient care that does not make heteronormative and cis-normative assumptions about family planning and fertility.

On behalf of Egale, thank you for your attention. We look forward to working with you further.

• (1605)

**The Chair:** Thank you very much. You get extra points for finishing a little early.

Now we go to Ms. Bloch for 10 minutes.

**Ms. Giselle Bloch (Board Member, Toronto Pflag):**

Good afternoon, Mr. Chair and members of the standing committee.

Thank you for inviting me to participate in this important meeting on LGBTQ2 health. My name is Giselle Bloch, and I'm honoured to be here today.

I'm not a scientist, a researcher or an expert; I'm a parent, and I love my three children, two of whom are LGBTQ2.

As I accompanied one of my adult children along his journey of transition, I quickly learned how poorly society views transgender folks. I resolved to be an ally by supporting this community. Since my personal experience is mainly with trans folks and their families, I will focus my remarks on that segment of the LGBTQ2 population.

I'm a board member with Toronto Pflag, a volunteer-run charity whose mission is to promote the health and well-being of LGBTQ2 people and their families through support and education and to keep their families together. Over the past four years I have heard hundreds of personal stories from transgender individuals and their families, and I will share some of their perspectives today.

The first area that I would like to address is access to services.

Family physicians are typically the first point of contact for patients regarding their health care. Many are reluctant to provide their trans patients with comprehensive health care. Some will flatly refuse to treat them, and some will continue caring for them but are reluctant to prescribe hormone therapy. While many family doctors may claim that hormone therapy is outside their realm for transgender patients, they will routinely prescribe hormone therapy to cisgender patients.

Trans patients are usually referred to an endocrinology specialist, for which the wait time can be six months or longer. Because the highest risk of suicide for a transgender person occurs during the time between declaring their trans identity and actually beginning to transition, this lengthy wait time may be life-threatening for some folks.

Coverage for medical interventions and surgeries varies widely across provinces and territories. The onus rests on the trans

individual to find out precisely what the requirements are, to obtain the appropriate letters and sign-offs from their health care practitioners, and to ensure that everything is submitted to their ministry.

Some trans individuals have to fly across the country for their surgery. Should complications arise once they return home, they are forced to go to their local emergency departments, where there may be a lack of competence in treating trans patients.

This past week, a young man very happily told me that he was just approved for his top surgery. He was so excited to be seen as his true gender when he starts university this September. When he called the clinic to book his appointment, he was told to call them back in July just to schedule the consultation, which will likely be in November or December, and the surgery itself maybe six months to a year after that. He broke down in tears when he found out that he may have to wait another year and a half to two years before he can have this surgery he so desperately needs.

The second area I would like to address is respectful treatment.

Some of the personal stories I've been privileged to hear have been very positive, while others have been those of emotional pain, discrimination and trauma. Many health care providers lack the appropriate knowledge or skills to treat and care for trans patients. Some are insensitive or even demeaning to trans identities. Some practitioners will continue to use the wrong name and pronouns even after being asked to use the correct ones when a trans patient's presentation does not align with the sex listed on their health card.

Some trans patients experience overt aggression. I've been told that folks have been ridiculed when their identity has been discovered. They've heard remarks like, "So do you like both men and women?" or "Oh, so you're not a real man."

Trans patients have heard health care practitioners openly discussing their bodies and their gender identity with other staff in front of patients. Some are asked inappropriate questions unrelated to their visit. One person told me that a technician setting a cast on her wrist asked her how she had sex.

Just a few months ago a woman told me about the time she went to a lab for some blood work. She presents feminine, but she hasn't received her new ID yet. When she handed in her requisition and ID to the receptionist, she politely asked if the technician could please use her new female name when she was called. When the technician bellowed out her old male name, she froze. The technician called the name again and she was immobilized. Then the receptionist stood up, pointed to her and said loudly, "That's him." Most of the people in that overcrowded room turned and stared at this woman who was just called "him". They started whispering to each other and she just sat there crying into her hands until she finally found the strength to run out of the lab without getting her blood work done.

• (1610)

These acts of discrimination and transphobia have detrimental effects on trans individuals and deter them from accessing proper health care. They may feel that their health care needs are not as important as those of their cisgender peers.

Many health care practitioners are also unaware of, or choose to disregard, organ-specific screening tests that must also be performed on trans patients, such as Pap tests or PSAs, which may trigger gender dysphoria. As a result, they may neglect their health care altogether, so that when these cancers or illnesses go undetected, it places a greater burden on our health care system in the long term.

The third area I would like to address is the impact on transgender individuals.

Regarding mental health, our society burdens trans folks with stigma and shame. Couple that with discrimination, harassment and even violence. The high level of vigilance that transpeople are forced to maintain takes a big toll on their mental health.

The suicide rate in the transgender community is extremely high. Mental health issues are high and so is substance use, physical and sexual assault and harassment. There is also discrimination in housing, employment, access to health, education and social services, as well as poverty.

While 4% of the general population will attempt suicide, over 40% of the trans population will attempt suicide, yet trans folks comprise only about 1% of the total population. Why is this number so disproportionately high? It's clear that the manner in which our society perceives and treats its trans members takes a very large toll on their mental health.

Regarding emotional well-being, some parents of trans youth have told me that their kids are suicidal, since they think everyone hates them just because they are transgender. Some parents say their kids can't go to school because they've been bullied or assaulted and have anxiety or depression as a result.

I've been told by trans folks that they have been spit on, verbally abused, taunted in public, threatened and physically forced out of washrooms. One woman told me that someone once walked past her on the sidewalk and then turned around and assaulted her from behind, while calling her names that I won't repeat here. Whenever she walks down any sidewalk alone, she is terrified. No human being deserves to be treated that way.

Regarding relationships and family, the strongest indicator of the future success of a transgender person is family support, yet far too many transgender people are rejected by their families when they reveal their trans identities. Some parents may begin to accept their kids after a few years, but especially for youth, the critical time is right at the beginning.

In Canada, 40% of youth experiencing homelessness are LGBTQ2, yet only 10% of the population is LGBTQ2, while 47% of transgender youth consider suicide, but that number drops by 93% when they are supported by their families. These numbers speak for themselves.

Trans youth lacking family support, or any transgender person lacking social support, will often encounter barriers in accessing care and too many of them are unable to advocate for themselves.

I propose that we take a coordinated approach to creating a culture in Canada that is inclusive of gender identity. Gender identity must be taught to all students in schools across Canada, beginning in kindergarten. As a result, transgender identities will not be stigmatized when these youth become our future health care professionals and leaders.

Trans-competent care must be incorporated into the curriculum in medical and nursing schools, as well as in specialty and technician positions.

Members of the transgender community must be involved in the development and implementation of this inclusive curriculum and the protocols for culturally competent care.

Non-discrimination policies must be mandated and prominently displayed in all health care areas and enforced. These facilities should have gender-neutral washrooms and changing spaces should be non-gendered and private.

As an incentive to be more inclusive, federal grants could be awarded to institutions and programs that teach postgraduate-level trans health care.

Finally, as a society, we need to build up a strong system of supports and resources for trans individuals and their families. We need broader community engagement and education. We need transgender-specific mental health services and we need medical care support and mental health services that are readily available and easily accessible.

Thank you for this opportunity to participate today.

• (1615)

**The Chair:** Thank you.

Before I start our first round of questions, I'd like to introduce our new parliamentary secretary, Pam Damoff.

Welcome to our committee.

I want to thank John Oliver, who is not here. John is not running again and he has stepped down as parliamentary secretary. He always added a lot to the committee over the last three and a half years or so, and I wanted to thank him.

We're going to start our first round of questions with Mr. McKinnon.

You have seven minutes.

**Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.):** Thank you, Chair.

Thank you to all of you for being here today. I appreciate your testimony. There's a lot of stuff coming at me, so I'm not sure I captured it all. I may overlap on some of my questions.

I'll start with Egale.

There's still a long way to go for equality, but there have been some gains in terms of rights for LGBTQ2 individuals in recent years. The legalization of same-sex marriage and the addition of gender identity and expression to the Canadian Human Rights Act are signals to the Canadian public that we are all equal regardless of our differences.

What influence, if any, have these legal gains had on discrimination against and the stigmatization of LGBTQ2 individuals?

**Mr. Richard Matern:** They're significant. The effect and impact can't be underestimated.

However, we do see a discrepancy between those legal wins and what's actually happening on the ground. It's evidenced through research. It's evidenced through the anecdotes that you hear.

There needs to be a multipronged approach. Winning legal rights is part of it, but there has to be an ongoing transformative societal change around all these gaps. The health sector is a significant one, as you heard, but it also includes other areas, from education to criminal justice to just community change in general. A lot of what we still need to do will happen on the ground. It happens with working in communities, and the health committee study that you are beginning is a big start and an important start because this is such a significant area. It's just continued work.

However, I can't overemphasize and I repeat what Lori talked about, which is collecting data and having adequate data and evidence that show those disparities so we can then take action and have evidence with which to move against.

**Mr. Ron McKinnon:** It has had an impact on health. Would you say that was a significant impact on health care?

**Mr. Richard Matern:** With the legal...?

**Mr. Ron McKinnon:** Yes, the legal changes.

**Mr. Richard Matern:** I'm not sure. I think that's the thing. We're not at the state where we can say whether the legal changes had a significant impact or not, and that's why we need more data.

**Mr. Devon MacFarlane:** I could speak to that a little bit.

I spoke to the Senate committee around Bill C-16 and part of what we brought forward was that in the states where protection for marriage is in place, where marriage equality is in place, compared to states where it isn't, the recent mental health outcomes are improving. In Canada, we're in a really strong position given the legal progress we've made. It's now about how we bring this to life, because the health outcomes will follow the legal progress, but it will

move much faster, very much faster, if we put a concerted attention into some really strategic places.

• (1620)

**Mr. Ron McKinnon:** Thank you.

Would anyone else care to comment on this?

**Dr. Lori E. Ross:** I would perhaps just add that different people within the LGBTQ2 community have differential access to those legal gains. It requires some resources to be able to take advantage of those gains in many cases. I think as with all health disparities, those who are most marginalized, we see the greatest disparities there. They're also the people with the few resources to access, for example, legal protections. I think that we may not necessarily see the breadth of health gains that you would hope to see simply because there are so many people who are really at the bottom of the socio-economic ladder and are not experiencing the same benefits as those who are at the higher end of the socio-economic ladder.

**Mr. Ron McKinnon:** Thank you.

I'll stay with you, Dr. Ross.

The available data on health of LGBTQ2 individuals is often viewed as incomplete or partial. Based on your knowledge, how could the federal government working collaboratively with the provinces and territories help to address this situation?

**Dr. Lori E. Ross:** I think that there are already some important gains under way. I know we have added a question on gender identity to one recent population-based survey and that there's intention to have that question or similar questions included in future Statistics Canada surveys. I think that's an important step.

We do still have a number of federal surveys, though, that don't include questions on sexual orientation and gender identity. I used as one example the Canadian income survey, which currently doesn't have those questions. Knowing that poverty is a very significant determinant of health, it would be important even in understanding health to have those questions there.

There are also data that are collected at the level of other jurisdictions such as the Canadian food security survey, which doesn't currently collect data on sexual orientation and gender identity. There are many opportunities there for collaboration with provincial, territorial and municipal levels of government to ensure that better data are collected at those levels in order to give a national picture.

**Mr. Devon MacFarlane:** Perhaps I could expand on that a bit. Another really significant area for improvement would be around health care administrative data. For instance, for those of you with OHIP cards, at registration we could be asking questions about sexual orientation and gender identity in a way that's private and kept protected. That then allows for much a better analysis about what's happening as people move through the health care system.

**Mr. Ron McKinnon:** Thank you.

Ms. Bloch, the attitude of health care workers is important and has a significant impact, as you said. How do you suppose we could address this problem? Is it a matter of education, training?

**Ms. Giselle Bloch:** It's both of those things. I think it needs to start in school with early education. Then there needs to be training in medical school and all the various specialties and different areas, including nursing and social work.

**Mr. Ron McKinnon:** Would anyone else like to comment on that?

**Mr. Devon MacFarlane:** There is work happening already.

Part of Rainbow Health Ontario's role is to provide health care training for folks who are already practising. We've been doing that for about 10 years. In Ontario we've reached about 40,000 providers, but when we're looking at 600,000 to 800,000 people who work in health and social services in Canada, that's a small fraction. But yes, we're already able to provide some of that training, looking at the clinical issues in particular.

**Mr. Ron McKinnon:** In the six seconds I have left, could you guys give us guidance or a recommendation regarding the terminology the committee should use in its report regarding LGBTQ2, LGBTQ2S, and so forth?

**Ms. Giselle Bloch:** LGBTQ2.

**Mr. Richard Matern:** At Egale the acronym we use is LGBTQI2S, to include intersex.

**Mr. Devon MacFarlane:** At Sherbourne we use LGBTQ2SQ.

**Dr. Lori E. Ross:** So we don't all necessarily agree—

**Voices:** Oh, oh!

**Dr. Lori E. Ross:** —but I think it's important to consider that just the way in which this meeting was set up, intersex was not included. I didn't address that in my remarks, given that it wasn't included, but I think it's an important consideration. Are intersex issues within the purview of this study? I would suggest that they should be.

I think it's also important to have explicit inclusion of the “2” or “2S” to ensure that two-spirit issues are included.

● (1625)

**Mr. Ron McKinnon:** It wasn't a fair question for six seconds. I'm sorry.

Thank you.

**The Chair:** Now we go to Mr. Deltell.

Welcome to the committee.

**Mr. Gérard Deltell (Louis-Saint-Laurent, CPC):** Thank you so much, Mr. Chair. I am the Marilyn Gladu of the day. I'm very pleased to be here.

[Translation]

Dear friends, good afternoon.

Ladies and gentlemen, welcome to your House of Commons.

Your presentations are always very touching and sometimes even quite poignant, especially yours, Ms. Bloch, about the reality that people in the LGBTQ community are still experiencing.

Perhaps Mr. MacFarlane or Mr. Matern could answer the questions that come to my mind regarding seniors in the LGBTQ community.

[English]

As we all know, our older citizens of the LGBTQ community were born and raised in a country where it was illegal for them to be what they were. For most of their young and adult life, male or female, it was tough for so many of them to have to live in the closet and sometimes to get out of it. Then when they reached the age of 60 or 65 and went into a seniors home, they would have to live the same situation again.

[Translation]

I'm a former journalist. About 10 years ago, I talked about the situation of those seniors who have to come out of the closet again—an unfortunate expression—when they go to live in seniors homes. It's a very difficult situation. It's already been 12 years or so since I left the world of journalism.

Do you feel that, even today, people in the LGBTQ community who, in the winter of their lives, live in seniors homes face the same stigma as they did in their youth in the 1970s?

[English]

**Mr. Devon MacFarlane:** My apologies if I misunderstand your question. My French isn't what it used to be.

To my understanding, yes, for LGBT seniors there are people who go back into the closet and who have to. There are also a number of long-term care homes in Canada that are starting to very actively work to create conditions where LGBT people are welcome. This is by no means all care homes; it's a few. We have some early strengths. Some areas can be expanded. For instance, the City of Toronto produced in 2007 or 2008 an initial version of some guidelines for long-term care homes. They've just re-released them.

So yes, there are problems. People are tremendously afraid. We also have some potential to build on this.

**Mr. Gérard Deltell:** I remember that people have said it's better to just have an LGBTQ house for them.

What do you think of that?

**Mr. Devon MacFarlane:** One agency in Toronto called the Re kai Centres is looking at having an LGBTQ wing on the floor. Some people may not want to be in an LGBTQ-specific wing and some might.

I think it's more how do we set up a range of options that can meet an individual's own comfort level and preference.

**Mr. Gérard Deltell:** Do you see any change in the minds of people? Maybe Mr. Matern could participate in the conversation.

Maybe 10 years ago they were not ready to welcome that kind of new reality of today and now they have to move on.

**Mr. Richard Matern:** Do you mean a change in the institutions themselves?

**Mr. Gérard Deltell:** In the institutions, and also in the people who are not LGBTQ.

**Mr. Richard Matern:** I think there are changes for sure.

I think the present fear is still.... I don't know if that's changed. Perhaps what people actually experience especially as they age.... When they are worried about losing their autonomy and decision-making abilities, the fear overrides any kind of progress, perhaps, that has been made in change of attitude. I think that's why special care needs to be taken to train service providers and to perhaps even add a credential system of some sort to long-term care facilities, so that becomes less of a concern. At least they have that to fall back on as well.

**Mr. Gérard Deltell:** Mr. MacFarlane.

**Mr. Devon MacFarlane:** To add on that a bit, some of the challenges in long-term care facilities is that as people age and experience cognitive decline, they may lose some of their filters. While people may have previously been supportive of LGBTQ people, all of a sudden really homophobic language can start coming out of their mouths and prejudiced language on a number of fronts.

That's one element of the challenges. Even as society changes, the compatriots of LGBTQ seniors in long-term care homes are also a product of their times.

•(1630)

**Mr. Richard Matern:** I would also like to add something to that.

In a survey that Egale did of both service providers and older people, the top concern among both of them was the fear of having queer and trans seniors going back into the closet. As service providers we're concerned as well. That was a recent survey. The fear is present amongst the staff.

**Mr. Gérard Deltell:** I'd like to talk about the transgender people and especially the youth—40% of them...suicide ideation...instead of for people who are....

My question is about the senior citizens. How do they live through that? Transgender was not a big issue for elder citizens. Is it the reality now?

**Ms. Giselle Bloch:** There certainly are now.... It depends what you consider to be senior.

**Mr. Gérard Deltell:** Well, okay, I have a big problem there. I mean 60 plus.

**Ms. Giselle Bloch:** Okay.

I do know some transgender people in that age bracket. They're out and finally able to live as who they couldn't be for a long time. I don't know personally very many over 60.

**Mr. Gérard Deltell:** Thank you, Chair.

**The Chair:** Now we'll go to Mr. Davies.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you.

Mr. Matern, one of your recommendations, which are very helpful by the way, is to eliminate the blood donation ban on men who have sex with men. We know in the last election there was a promise by the current government to eliminate the ban. It was for five years, but they've reduced it to one year.

I'm aware that Egale Canada Human Rights Trust has launched an online campaign calling for an end to what's referred to as the "discriminatory" ban on blood donations from men who have had sex with men in the past year, noting on its website that "Gay is not a blood type". It goes on to comment that there's a real discriminatory element to it. The current plan is very outdated.

To your knowledge, Mr. Matern, is there any scientific basis to retaining this one-year ban on blood donation from men who have sex with men?

**Mr. Richard Matern:** From what I understand, there are studies being done to confirm the safety of it. I understand that there's already data that exists. There is no scientific evidence.

**Mr. Don Davies:** It's my understanding that heterosexual men can engage in extremely high-risk behaviour and there is no automatic ban on their donating blood because of their identification. Many suggest that there should be a behaviour-based exclusion, if anything, but not a rank discriminatory stereotype view.

Do you agree with that?

**Mr. Richard Matern:** I agree with that.

**Mr. Don Davies:** Thank you.

There's been so much rich testimony here that we need to keep you here for a few days, I think.

It strikes me that there are a lot of elements and layers to the issues that we're about to explore. One of the common ones is the mental health element. That seems to be pervasive across....

I want to start at the very beginning, Mr. Matern. You commented on this troubling issue of non-consensual gender assignment surgery upon infants—young people who have ambiguous sexuality—and I'm just curious. If I have your recommendation correct, you were suggesting that there be a wide consultation about how best to handle it. Do you have any suggestions to give the committee about how we should better handle the issue of infants or children who are born with ambiguous sexual organs?

**Mr. Richard Matern:** The first thing is addressing the Criminal Code, which has the exception in section 268 that enables that to occur. The initial step, we think, aside from the consultation, is amending that Criminal Code element.

**Mr. Don Davies:** Thank you.

Mr. MacFarlane, by the way, most things about me are not as good as they used to be, including my ability to speak French.

I want to ask you a question about intersectionality, which also seems to be a very common theme here. We can have a woman who's lesbian, who's indigenous, who's poor, who's a woman—

•(1635)

**Mr. Devon MacFarlane:** She may be a parent.

**Mr. Don Davies:** —who may be a parent. There are all sorts of elements. I'm just wondering if you can unpack that a little bit for us and maybe tell us how we could address this as a federal government.

**Mr. Devon MacFarlane:** I think it is in taking that lens of the complexity of what goes on with people's lives. Sometimes when people think about a population, they tend to think about who they see and who they're most familiar with. Part of it is thinking about who may have the greatest barriers, because if we can improve the situation, access the care and so on, for folks who have more barriers, it'll raise the bar and open the doors for everybody.

For me, I'm a transperson, but I'm white and I get read as a man. My ability to move through the world and navigate things is a lot easier than folks who may be trans but not white, who are dealing with racism because we also know that, for instance, around cardiac care, about speed of care, for folks who are indigenous or racialized it's often delayed, often poorer. Being aware of all this, when we're looking at data, for instance, being able to get this aggregated data, we can look at what's going on specifically in different populations. We can see where we are doing well and where we can do better. It's critical.

**Mr. Don Davies:** Thank you.

Dr. Ross, if I have this correct, you said that in the GLBT community the rates of suicidal ideation were three to four times that of the general population, but among bisexual Canadians, it would be six times. Do I have that correct?

**Dr. Lori E. Ross:** That's correct, yes.

**Mr. Don Davies:** Basically, suicidal ideation among bisexual Canadians is higher than for heterosexual Canadians and gay and lesbian Canadians. Do you have any idea why that is?

**Dr. Lori E. Ross:** We've been doing some research to try to understand why, not only for suicide, but for other mental health outcomes as well, we see the same pattern where bisexual people have the poorest health outcomes. There does seem to be a major role for discrimination and associated lack of social support.

Many bisexual people are isolated in terms of lacking a community of support from other bisexual people. Many bisexual people face discrimination, not only from heterosexuals but also from gay and lesbian people, and so may not feel that they have a welcoming source of support within the broader lesbian and gay community. As a result of that, many are quite isolated with respect to their sexual orientation, and they lack support in that way.

Also, the data suggest that in terms of economic disparities, bisexual people also fare the poorest relative to other sexual orientation groups, so it's also very likely that the economic stresses that bisexual people are dealing with are also contributing to those mental health outcomes.

**Mr. Don Davies:** You commented on the community health survey, and we know that it includes a question on sexual orientation and that the results of that survey have been used by researchers to assess health inequalities in Canada.

A study in 2017 tested the sexual orientation question posed in the CCHS and estimated that approximately 14% of sexual minorities would not be identified through that question. Do you agree that the question should be changed to better measure health care inequalities experienced by sexual minorities? If so, what would be your recommendation on that?

**Dr. Lori E. Ross:** I do recommend that it needs an update. It has three options using language that is not necessarily the language that the community would use.

I would suggest that some consultation would probably be warranted before deciding on specific wording, but we should look at adding additional options to that question in order for people to identify. We also need to disentangle it. Right now, the way the question is worded is primarily identity-based, but the definition that's used for clarity is behaviour-based. We're actually conflating two different dimensions of sexual orientation, which is problematic in terms of interpreting the data. We really need to tease those apart and ask separately about one's self-identified sexual identity and one's sexual behaviour.

**The Chair:** The time is up.

We now go to Mr. Ayoub.

• (1640)

[*Translation*]

**Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.):** Thank you, Mr. Chair.

Dear witnesses, thank you for your testimony.

I am the member for Thérèse-De Blainville, a riding in the northern suburbs of Montreal. I have been involved in my region for a very long time. Recently, I invited my colleague Randy Boissonnault, who is the Prime Minister's special advisor on the LGBTQ community file, to come and see what was happening in my community. I had the impression that the LGBTQ community did not exist in my region. Of course, I knew that this was not the case, but the lack of statistics, knowledge and cohesion between organizations is clear. Each organization has a certain specialization and those organizations are often based in Montreal. Since there is little assistance, young people in the suburbs are redirected to the big city. Basically, they find themselves disadvantaged and become easy prey, subject to all kinds of pressures, good and bad.

How do you see that situation? How do you see cohesion between organizations to ensure that service is provided outside major centres? How do we start? What directions should we take, as a federal government, to change that?

[*English*]

Monsieur Matern, perhaps you could start.

**Mr. Richard Matern:** We've noticed a lot of gaps in service between rural and urban organizations. Indeed, with any strategy—

**Mr. Ramez Ayoub:** I'm not in a rural area. I'm in a suburban area. It's not very far from the—

**Mr. Richard Matern:** If there's any type of capacity building that the federal government could support, that would be of assistance. For instance, for seniors organizations, at Egale we're trying to link them together because there are a lot of organizations throughout the country doing different work. We're trying to help coordinate them and refer people accordingly.

Many agencies are likely stretched and don't necessarily have that outreach or coordination capacity, so any federal support that can enable coordination or have a role such as we do at Egale that can help coordinate organizations across the provinces or across the country where linkages can be made and have a person responsible for that would be a great assistance.

**Mr. Ramez Ayoub:** Mr. MacFarlane.

**Mr. Devon MacFarlane:** I think there are a number of ways of approaching it.

At Sherbourne Health—we're based in Toronto—we've been providing LGBT health and a range of community services and supports for quite some time. Recently we got some funding for a black queer youth mentorship program that is not downtown Toronto-specific. Yes, some of the groups are running there, but we're also running groups in suburbs like Scarborough and Etobicoke outside the downtown core, in part because not only is getting to the downtown core so difficult but also people need supports where they are so that they aren't forced to move, even just from the suburbs into the cities.

There are a range of ways. Part of it is through funding. Part of it is through organizing.

Here in the Champlain region—the greater Ottawa area, for those of you who aren't from Ontario—geographically we have some mechanisms for organizing. There's something called the regional planning table for trans health, which looks at how we organize trans health services in Ottawa as well as in the suburbs and through Hawkesbury and Cornwall, and up through Petawawa and Pembroke. Sometimes it's also about how you look at things, and provide some funds and infrastructure for organizations to look at that region from that perspective and say, "What's already happening, and how can we grow it?"

•(1645)

**Mr. Ramez Ayoub:** Thank you.

The other topic I want to specify is the statistics. If you don't have statistics, it's very hard to have funding. How can we get those statistics? What is the trigger? What is the challenge? What can we as the federal government do to change that?

**Dr. Lori E. Ross:** I think there's a lot that can be done working through Statistics Canada. In Canada, our population-based data on sexual orientation and gender identity are greatly lacking compared to that in other countries. I feel it's a scenario in which we are quite behind. I think there's a lot of room for further development there.

I think that in getting at the issues you're talking about, we need to be able to have data at a more local level as well. That's why there's room for collaboration with other levels of government in terms of the data that they are collecting.

**Mr. Ramez Ayoub:** Do you have any specific things you know we should do?

**Dr. Lori E. Ross:** One specific suggestion would be in terms of the homelessness point-in-time counts, which are done at the municipal level. Right now, it's patchwork. Some municipalities collect data on sexual orientation and gender identity and others don't. That's a specific example where having those data that are collected municipally available at a national level would be very

advantageous, particularly knowing that so many LGBTQ2SQ people experience homelessness.

A food security survey is another important one, since food security is such an important issue. There too, the questions on sexual orientation and gender identity are asked in some regions and not in others.

**Mr. Ramez Ayoub:** What are the other specific cases, outside of Canada, for which you said we're lacking those statistics specifically? What is the best of the business that can help us?

**Dr. Lori E. Ross:** Most often, we're going to U.S. datasets. That's because they ask a wide range of questions, not only on sexual identity, which is what we have so far, but also on sexual behaviour, which capture another segment of the community that may not self-identify but that may be engaging in behaviour that has implications for health. There are also questions on sexual attraction, which are really the questions we need in order to understand issues for youth, who, as you have heard, have particular vulnerabilities. For youth who may not yet be sexually active or who may not yet have decided on a sexual identity, sexual attraction is really the only way we can tap into that population.

**Mr. Devon MacFarlane:** If I can expand a little bit on that, we have one example that is strong but could be a lot stronger. Just a year ago, PHAC, in combination with StatsCan and some other partners, launched the health inequalities data tool. There are 65 indicators for health. Seventeen of them have information about sexual orientation—none about gender identity.

That tool is providing some of the best data we have so far. There are huge gaps, but there is a platform as we get these questions added in in various places. It's a game-changing tool, I think.

Another piece to this is that a lot of progress has happened in the States, particularly since 2010-11. In the States, in 2011, the Institute of Medicine, which is now called the National Academy of Medicine completed a study on LGBT health. They looked at all the research available on health in the States, just American data. Out of that, they developed an understanding of what their point in time was. They also, similar to what we've been talking about, identified all the gaps, and have put funding very strategically into addressing some of those research gaps.

If we could do something like that in Canada, it would be amazing. Some of the data I was talking about today around chronic disease prevalence is from the States, and it's been funded through those initiatives.

**The Chair:** Thank you very much.

Now we go to our five-minute round of questioning, starting with Mr. Webber.

**Mr. Len Webber (Calgary Confederation, CPC):** Thank you, Mr. Chair.

Also, Mr. Chair, we have a new addition to our committee. It's MP Pam Damoff.

Could you maybe clarify what her role is here?

**The Chair:** She's our brand spanking new parliamentary secretary.

John Oliver is not running again, so he has resigned as parliamentary secretary. Ms. Damoff is our new parliamentary secretary for health.

We've already had a discussion to talk about where things are going and what the committee is up to, so she's already up to speed and fitting right in.

**Mr. Len Webber:** Excellent.

You just took two minutes of my time, Mr. Casey. Wind it back again.

**The Chair:** I'll look after that.

**Mr. Len Webber:** Anyway, welcome, Ms. Damoff.

Witnesses, thank you for coming here today.

Mr. Ayoub alluded to MP Randy Boissonnault and his work at the secretariat. He's the Prime Minister's special adviser on LGBTQ issues.

Have any of you dealt with Mr. Boissonnault in your daily work?

• (1650)

**Mr. Devon MacFarlane:** In a past role, I served as a volunteer on the board of the Canadian Professional Association for Transgender Health, and at our last conference, we had a chance to sit down and meet with him.

Through Sherbourne Health, when he was announced, representatives from our organization were able to meet with him. We had submitted a letter about some priorities around LGBT health that could be addressed. Data was one of them.

**Mr. Len Webber:** Excellent.

**Mr. Richard Matern:** I haven't personally met with him, but Egale has, on an extensive level.

**Mr. Len Webber:** Excellent.

Mr. Matern, in your presentation you talked a bit about the homeless shelters and how a lot of these young LGBTQ community members feel unsafe.

Do you have a recommendation on what the federal government could do with regard to making them feel safer?

I have a history with the Calgary Homeless Foundation. I served on the board for many years.

This is something that should be fixed, whether it's supervision in these shelters...which I assume that they have.

Are there any thoughts from you on that, or any of you?

**Mr. Richard Matern:** Well I think as part of the national housing strategy, there are a few streams in there that can do targeted homeless initiatives that support LGBTQI2S youth. Supporting infrastructure would be key. I think that would be one large thing.

One of the youth at our centre had mentioned that in a shelter, because they were gender non-conforming, there was no gender neutral area for them to be in. They put them in isolation, basically.

**Mr. Len Webber:** Do you agree with isolation or separation?

**Mr. Richard Matern:** No. It's basically having a room that enables support for gender non-conforming and trans youth, so they don't have to be put in isolation.

That's an infrastructure issue, and I think that goes into part of the strategy to support shelters that provide services specifically to LGBTQI2S youth.

**Mr. Len Webber:** Mr. MacFarlane, you mentioned that in some health care facilities too, they sort of segregate the LGBTQ seniors.

**Mr. Devon MacFarlane:** I wouldn't necessarily describe it as segregating, as much as creating space where people go, if they want to go there. It's definitely not forced, but more voluntary. This has been an approach that has also been used in some shelter contexts, especially for folks who are trans.

If they only have a men's side and a women's side, what would best fit with their gender identity and how can they make them feel safe and welcome? There's some really interesting work out there that's happening in a few cities.

**Mr. Len Webber:** That's good. We're making progress at least.

**Mr. Devon MacFarlane:** We're making progress, yes.

**Mr. Len Webber:** Fantastic.

I'll address this question to Dr. Ross.

First of all, I find the things that you told us today with respect to discrimination in the LGBTQ community extremely disturbing. It's very sad.

Dr. Ross, we've all talked about the attempted suicides and the depression and anxiety in that community.

I'm looking at the Library of Parliament document that we all received, and there has been no mention about the physical health with respect to the LGBTQ community. First of all, it says here that there's a high rate of arthritis among lesbian women compared to heterosexual woman, and also asthma.

Do you have any comments on that at all? I find it quite surprising that there would be that difference.

**Dr. Lori E. Ross:** Yes.

I think we're only beginning to understand those kinds of differences, because we've only started to ask those questions from the data. Particularly for conditions that have a relationship to the immune system, there's a strong argument that people's experiences of accumulated life stress associated with discrimination are likely playing a major role in those kinds of chronic conditions in later life. There's also a lot of data on sexual and reproductive health outcomes for sexual minority women where we're seeing really striking disparities.

Again, we're only starting to be able to fully characterize what's happening there. It's important to situate what's going on largely within the impact of social discrimination and what that does to someone's body over a lifetime.



•(1655)

**Mr. Len Webber:** Ms. Bloch, you talked about education in the school system. Is there anything going on right now with regard to having it in the curriculum? Is that happening anywhere in the country that you know of? Is there any education in that manner?

**Ms. Giselle Bloch:** In Ontario it was just repealed.

**The Chair:** I let you go a little bit too far there. Sorry.

**Mr. Len Webber:** I appreciate that.

**The Chair:** You're way over, but it's my fault as I wasn't paying attention.

The answers are interesting.

Now we're going to Ms. Sidhu.

You have five minutes.

**Ms. Sonia Sidhu (Brampton South, Lib.):** Thank you, Mr. Chair.

Thank you, all, for being here.

You mentioned lack of training. What kinds of steps are needed for the first-line health workers who need to be trained?

I'm a representative of the Peel area. I would like to point out a new initiative called Rainbow Salad. It's an online portal that was formed by nine district health care organizations to provide support to the LGBTQ2 to raise awareness, to educate front-liners. Do you think this kind of idea is good for them?

**Mr. Devon MacFarlane:** Absolutely.

I think what you need to know is how people develop skills. Sometimes we think about training as coming into a workshop but sometimes that doesn't actually translate to the application of knowledge. We think about how we need to support people over time to develop and apply skills. Part of what we do at Rainbow Health Ontario specifically around trans health is we offer a series of training, two of which are accredited for continuing medical education credits. We don't just do those trainings. We also offer weekly mentorship calls. People such as physicians, nurse practitioners and the like can call in and get support around particular questions they have.

We want to take things further, because it's about engagement over time that will really help people develop the clinical skills that they need in order to be able to do this work properly.

**Ms. Sonia Sidhu:** There's the technology area.

Ms. Ross, can you elaborate on that? The suicide rate is very high in the young population. Do you think an app can be helpful to educate those youth?

**Dr. Lori E. Ross:** I imagine there's probably room for intervention with youth in terms of providing resources and information around suicide prevention. I'm not aware of any that currently exist that are LGBTQ2-specific.

I think we need to look carefully at directing interventions beyond the individual youth. Youth are experiencing high rates of suicidal ideation largely because of a lack of supportive environments, whether it be family, school or so on. It's important to have

interventions for youth for suicide prevention, but we also need interventions, for example, to make school settings safe for youth and to provide support and information to families so they can support their kids as well.

I think we need a multipronged approach in that regard.

**Ms. Sonia Sidhu:** Thank you.

Being a mother, can you tell us how we can educate the parents so they can be incorporated into the other parents population?

**Ms. Giselle Bloch:** I think talking about it and being open. The way that I have with my own children is I talk about them and talk about their experiences and my experience as a parent. Only one small thing has changed; otherwise, they're the same people who they were before I found out.

I think when people don't understand something they are afraid of it. It's really just education.

**Ms. Sonia Sidhu:** Did you find there was any difference in ethnic populations? Was there a different approach?

**Ms. Giselle Bloch:** Yes, in some there was. I don't want to generalize or stereotype, but yes, we do find that in some certain groups the biggest concern is, "What are the people in my community going to think?"

Once we get down to that, because usually they don't tell us that right at the beginning, it's easier to break it down for them and to help them through that and then to be able to tell people in their community, and chances are there will be many other people in their community experiencing the same things. Someone has to be the first one to say, "My kid is gay", or whatever it is. It's amazing how many other people will be saying the same thing to them.

•(1700)

**Mr. Devon MacFarlane:** May I expand a little on that?

**Ms. Sonia Sidhu:** Sure.

**Mr. Devon MacFarlane:** Through Rainbow Health Ontario, we did a province-wide needs assessment about supporting gender-independent kids and their families. Part of what we did was to reach out to particular ethnocultural communities and make sure that we're really spanning the diversity of our communities.

Part of what we heard is that there's sometimes a need for ethnocultural-specific support, which often requires some type of funding or some type of resourcing. People may or may not have all the time that's necessary to volunteer, but some type of ethnocultural-specific supports would make a world of difference.

**The Chair:** The time is up. Thanks very much.

Mr. Lobb, you have five minutes.

**Mr. Ben Lobb (Huron—Bruce, CPC):** Thanks, Mr. Chair.

The first question I have is in regard to the study itself. Obviously some of the topics that have been touched on today are provincial in nature, and I think you would all agree with that.

What advice would you give this committee or the Minister of Health, the Prime Minister or whoever? If we're trying to improve the health outcomes physically, mentally and so on, what is the role for this government or the next government's minister of health to do this?

I don't know if you have the answer today or if there is an answer, but what should we put in bold type, so to speak, on this report or study?

**Mr. Richard Matern:** One of our recommendations is on the accessible Canada act, Bill C-81, just to make sure that it incorporates measures to address barriers that disproportionately impact members of the community. That comes with the requirement that health care colleges have frameworks in place to protect LGBTQ2S service users, as well as mandatory competency training, which my colleagues have talked about. That's potentially one role.

Did you want to add to that?

**Mr. Devon MacFarlane:** Another piece of my understanding is there are sometimes federal, provincial and territorial committees struck. This might be something worth exploring there, but in that case I'd be sure to include folks who are active in LGBT communities in a range of ways in that, or in consultation with that, just because if there are folks around the table making the planning decisions who don't have the nuance of the experience, it might not have the desired outcomes. I would just suggest—

**Mr. Ben Lobb:** Well, you're talking about government. I don't know if it will ever do that.

**Voices:** Oh, oh!

**Mr. Ben Lobb:** However, that is a good point.

**Mr. Devon MacFarlane:** It may be worth trying something different, where you're having other stakeholders there in a way that works for the structure at the table as well.

**Mr. Ben Lobb:** Would anybody else like to comment?

**Dr. Lori E. Ross:** I would just add that many of the really important determinants of health within LGBTQ2S communities are social determinants of health such as poverty, housing and employment, areas where there's federal jurisdiction and federal opportunities, such as the national housing strategy and the new poverty reduction strategy. There's definitely room there. Even though those are not directly health policy directions, there is room there to have a major impact on health through acknowledging LGBTQ2S-specific issues within those areas.

**Mr. Devon MacFarlane:** If I could add a little more, my understanding is the federal government is the fifth-largest health care provider in the country, so there may be some action that the government itself can take and also be a model for others.

**Mr. Ben Lobb:** One example, which I know pretty well everybody has mentioned, and some of my colleagues have mentioned it as well, is around the mental health component.

I'm a rural member of Parliament, and we're in dire need of mental health support at all levels, every which way. Obviously there's a finite number of dollars for any government, and so on, so how would you propose that provincial governments make the best use of the mental health dollars so they help everybody? The rural people

would say, "We need this", and others would say, "We need that", but you want to try to make sure that everybody is getting the help. How do we do that?

**Mr. Devon MacFarlane:** I think part of it is that there are rural folks who are LGBT. Whenever you're looking at any particular element of it, how do we do this best?

In Ontario, for instance, there is a northern Ontario health equity strategy that Health Quality Ontario led, and we helped engage folks from LGBT communities in that strategy.

• (1705)

**Mr. Ben Lobb:** Is it something that should be general for everybody, or should there be a specific component for this community? That's what I'm trying to say.

**Mr. Devon MacFarlane:** I think some universal component is needed, but if we're going to be most effective, you need to delve into the communities that are struggling the most in order to actually have the impact.

**Mr. Ben Lobb:** Is there anybody else?

Do I have any time left?

**The Chair:** You have 28 seconds.

**Mr. Ben Lobb:** That's good, I think.

**The Chair:** Okay.

We'll move along to Dr. Eyolfson.

**Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.):** Thank you, Mr. Chair.

Thank you, all, for coming.

I'm very proud to be part of this study. I think it's a very important topic.

Dr. Ross, I agree with you completely that they need to be putting more of this kind of material in medical school curriculums. I can remember in 1990, as a second year medical student, talking about adolescent mental health. I don't remember the exact wording of this conclusion, but they said that a mark of good adolescent development was something to the effect of having long-term goals, a work ethic and the ability to develop heterosexual relationships. This was actually taught to us by a psychiatry professor in 1990 in a medical school class. I am glad we've come a long way since then. Even that long ago, we walked out of that class shaking our heads.

One question I have is one you mentioned—and maybe you can all chime in on this—in regard to the health care barriers this community faces. There is sometimes a controversy about the kinds of care that would be permitted or denied in health care facilities or long-term care facilities that are faith-based. For instance, it is well known that Catholic hospitals will not allow abortion services to be provided. There are religiously affiliated hospitals and personal care homes that do not allow medical assistance in dying, will not even allow the consultation to take place on their property.

Do you know of any data that shows there are more of these barriers for LGBT people in these kinds of health care facilities? Have any trends been noticed?

**Mr. Devon MacFarlane:** In one province there was a physician who had been trained to do many transition-related surgeries who was affiliated with a Catholic hospital and was not allowed to perform those surgeries there.

**Mr. Doug Eyolfson:** Does anyone else have any other experience or things they have heard?

**Mr. Devon MacFarlane:** There's sometimes considerable fear in LGBT communities around accessing services provided by faith-based organizations, as also for addictions and in some other areas. There's a lot of fear and a lot of concern.

**Dr. Lori E. Ross:** I'm not that familiar with the data on experiences accessing health care, but more familiar with data about the impact on people's mental health of challenging relationships with faith communities—coming out in the context of a faith community and not having a supportive reaction and the impact that has on them, or conversely, their coming out to a supportive faith community having a very positive impact on people's mental health. I think it's important to also recognize that in some cases these could be supportive spaces for people as well.

**Mr. Doug Eyolfson:** Sure. Thank you.

One issue we talked about that is tremendously hard on someone's physical and mental health is homelessness. We talk about it a lot. From what I understand, LGBT youth are overrepresented among the homeless—

**Dr. Lori E. Ross:** —and adults as well.

**Mr. Doug Eyolfson:** —and adults as well, yes.

From what I understand, many of them are simply young people who, on coming out to their parents, were literally expelled from their homes, shockingly.

Are you finding any trends among various demographics? Are young people from families of recent immigrants or different cultural or faith groups more represented among these, or do we have enough data to say?

**Mr. Devon MacFarlane:** I would talk to Dr. Alex Abramovich about that. Alex is one of the leading researchers on LGBT housing and homelessness.

**Mr. Doug Eyolfson:** All right, thank you.

I guess I'm running out of time on this now, so I'll just say that I wish I had more time.

Thank you to all of you for coming and for offering your testimony.

• (1710)

**The Chair:** Now we go to Mr. Davies.

**Mr. Don Davies:** Thank you.

Dr. Ross, if I understood your testimony, you mentioned that Canada is not comparing well to other countries in terms of how we are gathering and processing data. Is there a country that you could point us to that we could use as a model to better improve our data collection?

**Dr. Lori E. Ross:** Mostly we are using U.S.-based data. There are a number of U.S. population-based surveys that have excellent data on sexual orientation, and more recently, on gender identity as well. There's the behavioural risk factor survey in the United States. The national survey of family growth is another one that has very good data. There are a number of surveys there that we tend to use to answer the questions that we're unable to answer with Canadian data.

**Mr. Don Davies:** Would you recommend that we take some of those surveys and then just adapt them to Canada and implement them in Canada?

**Dr. Lori E. Ross:** Yes. I think there are opportunities to do that, definitely. I think we'll need to look carefully at the specific questions. They'll probably require some revision for the Canadian context because there is some difference in language between the two countries, but the overall constructs that they are assessing in those surveys would be very valuable in a Canadian context.

**Mr. Devon MacFarlane:** My understanding is that the U.K. census just this past year may have piloted asking questions around gender identity, so it may be worth looking at what they've done.

**Mr. Richard Matern:** To add to that, the U.K. also started a national action plan to address inequality among LGBT people in the United Kingdom. Preceding that was a national survey of LGBT people that they conducted, I think, from the Department for Work and Pensions. It was a voluntary survey sent out to members of the community. It's had a very high response rate, I think, in the hundreds of thousands, and a lot of the recommendations in the action plan were based on the results of that survey.

**Mr. Don Davies:** Okay, thanks.

This question may be for you Mr. Matern and Dr. Ross.

It strikes me that the stigmatization and the issues around mental health would start at a very young age. I'm not sure when our sexual identities and our gender identities develop, but it's when we're very young children.

I was struck by something you recommended, Mr. Matern, about national sexual health education beginning with adolescents and youth. Of course, it would be age appropriate, I'm sure, but would you recommend that we start right in kindergarten, preschool, grade one, making sure our educators and our children...?

Can we do a better job of making sure that we're all educated about the diversity in gender identification and sexual preferences at that early age in an appropriate manner, to sort of start attacking the early onset of stereotyping and stigmatization, and to create the conditions where people can be who they are very early? It strikes me that the process of hiding identity would be very painful and very debilitating at a young age.

Sorry. I don't mean to give the testimony, but what do you make of that?

**Mr. Richard Matern:** I can start.

I think part of what we hear anecdotally is that many people who work in the school system are scared themselves to bring up the issue. Therefore, there has to be some kind of protection for teachers and people who work in the education system, to be able to disclose or support students in creating at least the atmosphere of...either as national standards or a legal perspective where educators and people in the system are protected.

**Mr. Don Davies:** Mr. MacFarlane.

**Mr. Devon MacFarlane:** My understanding is that in B.C. the Pride Education Network, which is a group of LGBT teachers, has been working with the BC Teachers' Federation and, I think, also with the Ministry of Education to create some guidelines called SOGI 123, which are about how to do this in an age-appropriate way from kindergarten up.

**Mr. Don Davies:** Ms. Bloch, I haven't asked you a question. Would you have any comments on how we can better support...?

**Ms. Giselle Bloch:** I do know that kids as young as two and three understand their gender identity, so it does need to be taught as early as we possibly can, as early as school starts.

**The Chair:** Okay. The time's up.

That completes our round, but I'd like to ask a question of Mr. MacFarlane, if it's all right.

You mentioned you're transgender. Can you tell us your story, how your life unfolded and what are some of the challenges you've met?

**Mr. Devon MacFarlane:** Maybe what I can do is broaden that a little bit. I'm just thinking about how best to get at some of the root questions and issues that people sometimes wonder about.

I transitioned about 20 years ago, which was a very different time. I was very fortunate. When I transitioned at work, my employer had, months before, adopted a human rights policy that included gender identity and expression, which for me meant that I could come out and not be fired. That was a worry. I knew that I could go and talk with my union if necessary, but it was not necessary because the organization was very proactive.

For me, accessing medical care has been fine because I work in the health care system and know how to advocate. One of the things that some trans guys like me might struggle with is, depending on what organs you have, as Giselle mentioned, getting screened. What might it be like for somebody like me going for a mammogram or going for gynecological care? Many times those are set up as women's services, so what would it look like for somebody who looks like me to be sitting in a waiting room like that? There are different things like that in terms of what it's like to access health care.

I've been really fortunate in terms of family support. It took my dad about seven years. I love him, and he was supportive the entire time, but it took him about seven years to start using my name. He didn't have access to supports. As a parent, he didn't have access to the supports that he needed, to be able to know how to wrap his head around this because, again, it was a different time.

• (1715)

**The Chair:** You were 20?

**Mr. Devon MacFarlane:** No, I was not 20. A lot of trans folks look a lot younger than they are because of having two puberties, so I'm in my late forties.

**The Chair:** Okay, but you were 20 when the transition—

**Mr. Devon MacFarlane:** It was twenty years ago, so I was about 30.

**The Chair:** Oh, okay. Well, thanks for that.

Ms. Bloch, how did it affect you as a parent when you realized your children—I don't know. Were they gay or...?

**Ms. Giselle Bloch:** Do you mean both?

**The Chair:** Yes, both.

**Ms. Giselle Bloch:** When my children told me, it was a bit of an adjustment. My eldest, who had already come out as a lesbian four years earlier said—

**The Chair:** How old was she when she did that?

**Ms. Giselle Bloch:** He was 18 when he came out as a lesbian, and then at 22 he told us he was a transman. In the interim, our middle son came out as gay. I wanted to make sure that nothing was going to change.

In retrospect, of course, we're all brilliant. Nothing did change. This was the same child with the same wonderful qualities before he transitioned as now, except that he's a lot happier now.

**The Chair:** I just can't thank you enough for telling us your stories and sharing your information.

I do want to say, Mr. Ouellette didn't get a chance to ask a question.

Do you have one question you want to ask?

**Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.):** I have one question. I think also the parliamentary secretary might ask a question.

**The Chair:** Do we have unanimous consent?

**Some hon. members:** Agreed.

**The Chair:** Okay.

**Mr. Robert-Falcon Ouellette:** Thank you very much, everyone.

The federal government's been investing in health accord agreements, and in Manitoba, for instance, it's \$399.6 million for mental health and for home care. You also discussed the whole concept surrounding re-closeting in nursing care.

I was wondering if you would recommend that health transfers should also contain a section on LGBT2Q rights and considerations concerning those health accords.

**Mr. Devon MacFarlane:** Absolutely, I would strongly recommend that there be some earmarked funding and earmarked deliverables around that. Particularly around LGBT seniors, and also for younger folks who are dealing with disabilities, far more will interact with home care than will necessarily interact with long-term care facilities.

I remember having a conversation with home care case managers some years ago. They were asking, “How do I even broach this?” The particular case manager I was talking to was a lesbian, and she was saying, “I’m seeing these seniors who I’m darn sure are a couple, but they’re not framing themselves as a couple. They’re saying that they’re roommates.”

They were going in because there were health concerns, and one of them was becoming frail. They didn’t have legal status, and they weren’t going to have legal status because they weren’t claiming to be a common-law couple, which then had a lot of impact in terms of whether they would be eligible for survivor benefits. There were also questions about what would happen about substitute decision-making. This lesbian home care provider didn’t know how to open those conversations.

There’s a lot of vulnerability in home care as well as long-term care. There are particular issues again for transpeople about what questions you have to ask. If you have to provide very personal care, help them with bathing and toileting, and somebody’s body may not be what’s expected, how do you do that really sensitively and respectfully? Again, these are areas where there’s a lot of fear, and a lot of possibility for improvement and for good care with support.

• (1720)

**The Chair:** Ms. Damoff.

**Ms. Pam Damoff (Oakville North—Burlington, Lib.):** Thank you.

Also, thank you for the warm welcome.

**The Chair:** Ordinarily parliamentary secretaries don’t ask questions, but this is a special case.

I told you this was an interesting committee.

**Ms. Pam Damoff:** Oh, I had no doubt.

I have a question about medications, dosages and research. We know that not that long ago—and I think it’s still happening—research would be done on a 200-pound man and then the dosage would be adjusted for a woman based on weight. That’s starting to change, but I’m wondering if there are gaps when it comes to LGBT.

In particular, I’m thinking of trans individuals who are on hormone therapy or of someone who might be on the HIV cocktail. Is there any research that’s been done to see whether, say, someone’s heart medication is going to be effective based on those other medications the person might be taking?

**Mr. Devon MacFarlane:** That’s a really good question.

From my understanding, I don’t know exactly what’s happening. It’s coming up in terms of what should be prescribed, but it’s also coming up in terms of what lab values we should be looking for, because that’s a little different, too, and it’s often based on sex assigned at birth rather than what’s going on in somebody’s organ system.

There are definitely some areas for exploration and really teasing out what is going on right now. I’m sorry that I don’t have a more fulsome answer, but I can try to get one.

**Ms. Pam Damoff:** That’s okay.

**Dr. Lori E. Ross:** Perhaps I could add, though, that there is almost no research that’s looked at this. There’s a real lack of medical research on investigating what the long-term health outcomes even are for transpeople who have particular interventions or are using particular medications, much less the questions you’re asking about drug interactions or appropriate dosing. There is just an enormous need for research in those areas.

**Ms. Giselle Bloch:** Perhaps I could just add that when my own son was starting this journey, my mother said to me, “What are the health risks of him starting hormone therapy?” I said, “The health risks of him not starting hormone therapy are a lot greater, and we’ll probably find out down the road as they do more research.”

**The Chair:** Thank you very much, everybody. Thanks to the committee, and thanks to the witnesses for starting us off on this little journey that I think is going to be most interesting. I hope it’s beneficial to everybody by the time we’re done.

Thanks again, everybody.

The meeting is adjourned.





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