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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1535)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

Welcome to the 138th meeting of the Standing Committee on Health.

Several members of the committee are just returning from a trip. I'm not sure what you'd call it exactly, but it was an educational trip to Montreal, Winnipeg, Calgary and Vancouver. It was partially about LGBT2Q issues but also about methamphetamine, so it ties them together. We learned a lot.

I want to welcome our guests.

We're going to have 10-minute opening statements by each person.

First of all, we have Travis Salway, Ph.D., post-doctoral research fellow, School of Population and Public Health, University of British Columbia.

We have Alex Abramovich, Ph.D., independent scientist, Centre for Addiction and Mental Health.

From the Health Initiative for Men, we have by video conference from Vancouver, Greg Oudman, Executive Director.

From Pflag York Region, we have Tristan Coolman, President.

We'll start with Dr. Salway, with a 10-minute opening statement.

Dr. Travis Salway (Post-doctoral Research Fellow, School of Population and Public Health, University of British Columbia, As an Individual): Mr. Chair and members of the standing committee, it is a privilege to address you this afternoon. My name is Travis Salway and I'm an epidemiologist and a post-doctoral research fellow at the University of British Columbia, where I study how stigma and stress affect the health of sexual minorities.

In my statement I will use the term “sexual minorities” to refer to those of us who identify as bisexual, lesbian, gay or queer, as well as those who experience non-heterosexual attractions but may not easily assign labels to their feelings. I will not be speaking specifically about the health of transgender people in my statement as this is not my area of expertise; however, I do encourage the committee to consider how my recommendations may additionally benefit the well-being of transgender Canadians.

The rate of suicide in Canadian sexual minorities is unacceptably high, and this is why I'm here today. In the past 25 years we have seen dramatic gains in the legal rights and social status of sexual minorities in Canada, and yet despite these gains, at least one in six sexual minorities, a quarter of a million Canadians, have attempted suicide at least once. This rate is four times higher than the rate in the heterosexual population.

These statistics indicate that more government action is needed. Specifically, I will recommend action to increase the availability of and access to mental health supports though expansion of the Public Health Agency of Canada's community action fund; ban conversion therapy; and increase research on sexual minority people's health.

First, to give you some context and to situate my research, I will define the concept of minority stress. Everyone experiences daily stressors—a late bus, a deadline at work. Sexual minority people, however, experience additional stress because of their minority status. Minority stress comes in many forms and adds up over time because of repeated exposure.

Through my research interviews with adult gay men who had attempted suicide, there was seldom just one stress that caused the suicide attempt. Rather, multiple assaults and stresses accumulated. One man reflected upon a hurtful remark from his father, who saw a gay couple on television and reacted by calling them “mentally sick fruits”. This remark was internalized. It became an echo throughout the interviewee's life, reinforced when he was mocked or rejected by others in the schoolyard, in the locker room, online, but also later in life, even when, as an adult, he came out and tried to join a gay support group but found it hard to connect with other men there. This is how minority stress gets under our skin, into our bodies and into our minds. The stigma lodges itself there and slowly kills us from the inside.

Minority stress is not only about discrimination and hateful language. It also comes from within us, through low self-confidence and low self-worth. Another participant I interviewed talked about “withholding [the] major secret...of being gay”. He blamed his multiple suicide attempts on the fundamental pain associated with withholding this secret.

Withholding is something every sexual minority individual experiences. Even those of us who live in environments that are open and accepting of minority sexualities must repeatedly revisit the decision of whether to disclose and when it is safe to disclose our sexual minority status. This creates a particular kind of stress.

The many forms of minority stress and the accumulation of that stress over time take their toll on mental health. This is one important reason the policies and legal rights recognized in our country during the past 25 years have not yet fully alleviated the burden of mental health struggles among sexual minorities. But there is hope for sexual minorities who are struggling, and I want to offer some tangible ways forward today.

In Vancouver, where I work, one-third of sexual minorities we talked to want to talk to a health care provider about depression, anxiety, suicide or substance use, but are unable to do so. In response to this backlog of unmet mental health care needs and the limited available services offering sexual minority-affirming care, my colleagues and I have co-founded a collaborative of individuals and organizations in Vancouver—the LGBTQ2 mental health round table. Most members work for organizations that were established in response to the HIV epidemic, and that historically have received funding from the Public Health Agency of Canada's HIV and hepatitis C community action fund. We recognize that the same community-based infrastructure that was created to address HIV and AIDS is needed to similarly reach sexual minorities with unmet mental health needs.

The work of our round table is undertaken by volunteers and other individuals who are not formally tasked with addressing mental health-related epidemics affecting our communities. These individuals are nonetheless committed to this work because the levels of need are so high. Our work effectively reaches sexual minorities because it is led by organizations with long histories of working with sexual minority communities. For these reasons I recommend expansion of the Public Health Agency of Canada's community action fund to address suicide, depression, anxiety and substance use epidemics in the same way this fund has created equitable responses to the HIV and hepatitis C epidemics.

The research I have done on minority stress has allowed me to see with particular clarity the harm associated with an ongoing and overlooked practice here in Canada, that of conversion therapy.

Conversion therapy is an umbrella term for practices that intend to change an individual's sexual orientation and gender identity. It is among the most extreme forms of psychological abuse and violence, leaving those exposed to manage the stress associated with a severe form of withholding for many years. Conversion therapy is thus the sharpest edge of minority stress. For this reason, conversion therapy has been unequivocally denounced by the Canadian Psychological Association and multiple other professional bodies.

Despite those denouncements, in a recent Canadian survey, 4% of sexual minority men reported having attended conversion therapy. On this basis, as many as 20,000 sexual minority men and countless more sexual minority women and transgender people have been exposed. Exposure to conversion therapy was associated with numerous health problems in the study we conducted. Most notably, one-third of those who had completed conversion therapy programs attempted suicide.

Sexual minority youth are especially vulnerable to being enrolled in conversion programs against their will, yet in Canada we lack federal policies to protect our youth from these harmful practices. Many, if not most, conversion programs are practised outside health care providers' offices. Thus, the current situation in which some provinces ban conversion practices by a subset of providers is insufficient and inequitable. Therefore, I recommend a federal ban on the practice of conversion therapy.

Minority stress is harmful, but it is not the entire story of sexual minority health. From data gathered through the Canadian community health survey, we know that sexual minorities are less likely to be married or partnered, and thus miss out on some of the beneficial health, social and financial benefits conferred through partnership. Sexual minorities, most notably bisexual people, are more likely to be living in poverty. Even in environments where minority stress is diminished, sexual minorities often lack social support networks as robust as those of heterosexuals.

Those patterns are striking, because in the general population we see that partnership, income and social support networks are among the largest and most consistent protective factors for suicide. This suggests that the suicide statistics I shared with you earlier are products of more than minority stress alone. For this reason, we need to deepen and expand Canadian research on sexual minority people's health.

As others have stated to this committee, Canada lags behind other countries in the routine collection of sexual and gender minority data. The sexual and gender minority research office of the U.S. National Institutes of Health lists 13 publicly available national datasets that measure sexual or gender minority status. In Canada, we have just two.

The opportunities in harnessing multiple large, linked federal datasets to more fully characterize sexual and gender minority health issues have yet to be realized. I therefore recommend the addition of sexual and gender minority measures to all federally funded health surveys and for respondents of all ages.

Furthermore, much of the evidence I have referenced today stems from research supported by the Canadian Institutes of Health Research. This research has established initial Canadian estimates of the prevalence of health outcomes among sexual minorities that we're discussing today and has helped us understand some of the pathways through which minority stress causes these outcomes. However, acknowledging that we still have much to learn about the various other causes of ill health among sexual minorities, I recommend that special funding be identified to accelerate new research on the health of sexual and gender minority Canadians.

In closing, I believe the government actions I have recommended will make a substantial contribution to reducing the inequitably high rates of mental ill health for sexual and gender minority people in Canada. Again, my recommendations are, first, to increase the availability of mental health supports through expansion of the community action fund; second, to ban conversion therapy; and third, to increase research on sexual minority people's health.

I thank the committee for undertaking this study, a historic and pivotal step toward national leadership in addressing the health needs of LGBTQ2 people. Yet another profound effect of minority stress is that it often leads to a sense of hopelessness, and in this context, a federal study on the needs of sexual and gender minorities is itself a formidable intervention. Congratulations on this important work.

● (1540)

The Chair: Thanks very much. We appreciate your comments. It certainly reminds me of many of the things we've learned on our visits.

Now we'll go to Dr. Abramovich.

Dr. Alex Abramovich (Independent Scientist, Centre for Addiction and Mental Health, Institute for Mental Health Policy Research, As an Individual): Thank you, Mr. Chair and members of the standing committee, for the opportunity to take part in this historic study on LGBTQ2S health.

My name is Alex Abramovich and I am an independent scientist at the Institute for Mental Health Policy Research at the Centre for Addiction and Mental Health and an assistant professor at the Dalla Lana School of Public Health at the University of Toronto.

I have been addressing the issue of LGBTQ2S youth and young adult homelessness for over 10 years. I'm currently leading a study on transgender health more broadly. Today I will be speaking about these two topics.

I will use the term “youth" to refer to those between the ages of 16 and 29 and the term “cisgender”, which refers to people who identify with the sex they were assigned at birth.

There are approximately 40,000 young people experiencing homelessness in Canada and up to 7,000 young people experiencing homelessness on any given night across the country. Of youth experiencing homelessness, 25% to 40% identify as LGBTQ2S.

Identity-based family conflict resulting from a young person coming out as LGBTQ2S is a major contributing factor to youth homelessness and the most frequently cited cause for LGBTQ2S youth experiencing homelessness. The experience of homelessness is different for LGBTQ2S youth versus for heterosexual and cisgender youth. LGBTQ2S youth tend to become homeless at younger ages and experience homelessness for longer episodes compared to cisgender and heterosexual youth.

Some LGBTQ2S youth experience discrimination and violence at higher rates than do others. For example, transgender people of colour, especially young transwomen of colour, face the highest rates of discrimination and violence in shelters and housing programs and on the streets. They are more likely to experience violent crime, sexual assault and murder.

One of the biggest issues that LGBTQ2S youth face in shelters and housing programs and institutions more broadly is safety. Over the years my research has looked at the different ways that LGBTQ2S people are further marginalized and erased in institutional settings such as shelters and housing programs, making it difficult to quantify how many LGBTQ2S individuals are experiencing homelessness in Canada.

While research in this area has certainly expanded in recent years, there is still minimal investigation into these issues and large-scale data collection remains limited. Most of the research and point-in-time counts, or PiT counts, up until very recently have not included any questions regarding sexual orientation or gender identity.

Accurate prevalence rates are also dependent on a community's or system's data management program having been set up to include data on sexual and gender identity as well as the larger data management systems at the national level having been designed to capture and integrate this type of data.

For example, HIFIS, which is a comprehensive data collection and case management system used by housing and shelter programs across the country, provides individuals options to identify only as female, male or gender diverse and does not collect any data on sexual orientation. Even when we do collect inclusive data, many youth are missed because they do not access services given their safety concerns and difficulty fitting into the gender binary, since most programs are segregated by male and female floors.

Hidden homelessness, such as couch surfing, remains a significant issue among LGBTQ2S youth, especially for those living in rural and remote communities, making it difficult to accurately determine the scale of the problem. A lack of inclusive services and supports as well as the availability of fewer housing options to youth experiencing homelessness in rural areas may force youth to relocate from their communities and leave behind important social networks and emotional connections. Relocating to big cities in order to obtain inclusive services and supports can introduce a whole host of consequences, including worsened health, fewer social networks and support and increased risk of victimization and exploitation.

I recently worked with the homelessness partnering strategy on the development of two new questions focused on sexual orientation and gender identity, which were included in the 2018 national PiT count and were administered in over 60 communities across Canada. It has been only in recent years that the first population-based housing programs for LGBTQ2S youth have opened their doors in Canada.

A major milestone was the opening of the YMCA's Sprott House in Toronto in 2016, Canada's first LGBTQ2S transitional housing program. The biggest difference between Sprott House and many other housing programs is that all of their programs have been designed through an LGBTQ2S lens with the needs of LGBTQ2S youth at the centre of all aspects of the housing program. This has been an important step in the right direction and has inspired more programs to open and others to rethink how they deliver their services and whether or not they are inclusive. But we still have a long way to go.

● (1545)

Discrimination and social stigma have serious consequences on the health and well-being of LGBTQ2S youth, leading to significant mental health issues, substance use, anxiety, depression and high rates of suicide, especially for young transgender people. It is well documented that transgender individuals experience negative physical and mental health outcomes and high rates of disease burden, including high prevalence of mental health issues.

Still, trans health continues to be an understudied area. Gender identity information has yet to be routinely collected in administrative data, electronic health records and provincial and federal surveys, making it difficult to identify trans individuals within population-based data sources.

I'm currently leading a study that investigates the health care utilization trajectories and health outcomes among transgender individuals in Ontario, by linking health service data. This study uses high-quality data from primary care and psychiatric settings to identify a large number of transgender individuals in Ontario over the entire age range. It is the first study to identify transgender individuals in the ICES data repository.

This study is still in its early stages, so I can only speak to some of the very preliminary findings. So far, over 2,000 transpeople have been identified, and 50% of them are living in the two lowest neighbourhood income quintiles, compared to 37% of the general population. There are very strong links between income and health. Those living in the lowest-income level neighbourhoods tend to experience poor health outcomes compared to those who live in higher-income level neighbourhoods.

The preliminary data are showing significantly higher rates of mental health-related primary care and psychiatry visits, as well as higher rates of hospitalizations and emergency department visits due to self-harm and mental health-related reasons, compared to the general population.

There are different solutions to these issues, and I'd like to close with some recommendations.

Targeted strategies and prioritizing LGBTQ2S populations, especially youth, in Canada's homelessness, national housing and poverty reduction strategies provide an important opportunity to more comprehensively end homelessness in Canada. When government policies and plans to end homelessness prioritize disproportionately represented populations, including LGBTQ2S youth, they create life-saving policies.

The Government of Alberta has done some exceptional work in this area. I developed a targeted provincial strategy on addressing LGBTQ2S youth homelessness with the Government of Alberta and a provincial working group. This work was a result of their youth plan, which prioritized LGBTQ2S youth and stemmed from their 10-year plan to end homelessness, a first of its kind in Canada, and a truly important response that emphasizes longer-term solutions and prevention.

Six key recommendations were made in the final report, all of which were approved by the Alberta government and are in the process of being implemented. Targeted strategies such as this involve population-based housing programs, comprehensive education and training for all staff, and inclusive housing and shelter standards and policies, ultimately creating a standardized model of care and service delivery that meets the needs of everyone experiencing homelessness, regardless of their gender identity or sexual orientation.

I also recommend including sexual orientation and gender identity questions in all federal surveys, data collection systems and administrative health data to provide a better understanding of the health disparities and circumstances of LGBTQ2S individuals across the country.

When surveys do not present inclusive questions and response options, they perpetuate data erasure towards LGBTQ2S individuals and make it extremely difficult to collect data that accurately reflect the population.

I echo the recommendation to prioritize LGBTQ2S health research in Canada, particularly within the Canadian Institutes of Health Research and to develop the capacity for research focused on LGBTQ2S health. This is an incredible opportunity for Canada to better understand and address the health disparities experienced by LGBTQ2S individuals, and I'm truly honoured to be part of this important discussion.

Thank you.

● (1550)

The Chair: Thank you very much. We're honoured to have you here.

Now we'll go to the Health Initiative for Men, by video conference.

Mr. Oudman, you have a 10-minute opening statement. We look forward to your remarks.

Mr. Greg Oudman (Executive Director, Health Initiative for Men): Thank you.

Mr. Chair and members of the standing committee, it's a privilege to address you this afternoon. My name is Greg Oudman. I am the Executive Director of Health Initiative for Men, a community non-profit organization located in Vancouver that is both led by and run by gay men. Our mission is to strengthen the health and well-being of gay men toward a vision of gay men building healthy lives together.

You've heard from my esteemed colleagues about the results of research undertaken with sexual minorities and the continuing need for increased focus on this research. As a service provider, HIM is in a unique position in that we are able to put research into practice at the community level. Let me tell you a little bit about us. HIM was founded in 2008 by a group of community-minded thought leaders who were concerned about the lack of focus on the health of gay men in Vancouver's response to HIV and AIDS. HIM's inception happened at a time when there were elements of a perfect storm that were able to lead us to the development of a truly unique organization founded on the principles of for us, by us.

In the mid-2000s, the community was hearing increasing calls for effective programming for HIV/AIDS prevention and gay men's health at the same time that the region's primary health funder was looking to increase its focus on prevention. Community-based research was indicating that HIV infection and HIV and transmissible behaviours were on the rise. At the same time, testing for HIV was down in men having sex with men, especially in men under 30. The integration of the LGBTQ2 community into the mainstream as a result of expanded rights and increased societal acceptance meant that what were once traditional gay venues were disappearing. Gay men were increasingly living outside of traditionally gay urban areas, and instead connecting with each other through the realm of online networking. All of these factors led to an increasing awareness that innovative approaches had to be developed to significantly impact gay men's health.

It was into this environment that HIM was born as an organization with unique values that highlight the faith we have in our own community to be the authors of the most effective tools to ensure our own health. HIM's approach to gay men's health is an integrated one, understanding that sexual health is only one of several components of health and wellness. Physical, social and mental health needs are often drivers for more healthy, and sometimes less healthy, sexual behaviours. Very few of HIM's programs or interventions have a singular focus. All understand the role of syndemics in overall health outcomes.

HIM engages with gay men in the broadest range of ways to work with them to ensure the broadest of health outcomes. Interventions at HIM represent efforts designed to improve the sexual, physical, social and mental health of gay men, and are largely contained within health promotion and knowledge translation. They also relate to highly specific target populations, diseases and/or other important health factors or issues identified to be a priority.

Our health promotion efforts are based on scientific research and represent our largest mechanism for engaging with the health of gay men. Health promotion at HIM is delivered through a variety of methods, including social marketing campaigns, creation of unique and custom-tailored resources, health-centred communications and media, and educational and community engagement strategies. HIM recently partnered with a community-based research centre here in Vancouver to develop an official position statement on mental health and problematic substance use among gender and sexual minorities, including gay men. This statement outlines the impact of mental health on problematic substance use, highlights barriers to progress, and makes key recommendations to address issues related to mental health and problematic substance use. Much of the information I'm about to outline in this next section comes from the research done to inform that position.

We know that despite the experience of ongoing marginalization and oppression, gender and sexual minority individuals, including gay men, have made significant progress in human rights and recognition from broader society. Despite this progress, research demonstrates that gay men continue to be disproportionately impacted in terms of mental health and problematic substance use. As you have already heard, extensive research has shown that compared with the average population, gay men experience higher rates of mental illness, problematic substance use, and suicide. The overrepresentation of mental illness among gay men is also often accompanied by increased rates of problematic substance use, which are frequently part of a larger syndemic of interconnected health problems. For example, gay men are also shown to have higher rates of tobacco use, heavier episodic drinking, and nearly twice the level of substance use disorder as the general population.

This overrepresentation is also attributable to intersectionality, as key population segments of gay men also face additional barriers to accessing mental health and problematic substance use services, including racism, ableism, sexism, classism and other forms of oppression and discrimination. Some gay men identify with a combination of these social categories. Therefore, building services based on a singular aspect of their identity can represent a barrier to appropriate and effective care. The complexity of these intersecting identities requires a community-driven and evidence-based approach to ensure that the unique needs of diverse gay men are carefully considered in the delivery of services for mental health and problematic substance use.

● (1555)

Despite evidence of the disproportionate impact of mental health and problematic substance use in gay men, insufficient progress has been made to address this impact, and resources and support for addressing mental health and problematic substance use among gay men remain scarce.

Adequate treatment and prevention services in B.C. are not easily available to the general population and are often not funded by the public system. Most often these services are paid for out of pocket or through private insurance plans, while services that are publicly funded are often over-capacity and have extensive waitlists or challenging eligibility criteria.

The recent study noted by my esteemed colleague Travis Salway, which examined the effectiveness of integration of mental health services within a specialized STI clinic setting, found that 20% of respondents reported a recent unmet need for services related to mental health or problematic substance use, and 83% of those same respondents indicated they were comfortable talking with an STI clinic provider about mental health or problematic substance use. These statistics demonstrate both an unmet need and an untapped opportunity to address the specific mental health and problematic substance use needs of gay men.

As I've already noted, HIM is in a unique position in that it is a community-based organization that uses research to develop evidence-based practices. We actively engage in knowledge translation, which involves delivery of concise, clear and relevant translation of complex biomedical and/or health-related information and research to the community in a way that matches the community's needs.

Effective knowledge translation requires significant partnerships with researchers, universities and other research organizations such as the researchers you already heard from this afternoon. Knowledge translation initiatives work in conjunction with health promotion in that the goal for both is to create significant change in the health and well-being of gay men. HIM uses research such as that undertaken by Travis Salway and his colleagues to develop effective programming to address the challenge of mental health and problematic substance use. As I've already pointed out, HIM approaches all of its work from an integrated perspective, believing that social determinants of health are deeply interconnected and that the most effective programs and interventions are those that address more than one aspect of overall health.

Strong mental health supports good physical, sexual and social health. More than ever before in its 10-year history, HIM believes that specifically tailored mental health supports for gay men are desperately needed, including peer counselling, programming to address substance use and queer-focused suicide prevention programs, all of which are important in helping gay men to build healthy lives together.

Currently, Health Initiative for Men operates a professional volunteer counselling program, which at any given point engages 15 to 20 professionals—social workers, psychologists from the community, as well as students in the same fields—to volunteer their time to offer clinically supervised, solutions-focused sessions with an option for follow-up case management. This free program prioritizes gay men from economically disadvantaged or marginalized backgrounds.

HIM also offers a coaching program operated by volunteer peers, mentors and professional coaches who are supervised by an expert coach to offer multiple goal-focused sessions utilizing a HIM-designed motivational interview-based system.

HIM also offers specialized professionally facilitated closed mental health support groups that focus on specific needs, including issues such as anxiety and the problematic use of substances like crystal meth.

HIM also offers a subsidized counselling program, which provides reduced-rate counselling by registered and independent therapists, social workers and psychologists, all vetted by HIM's mental health advisory committee. These sessions have no session or cap limit and focus on clients with medium-to-high annual incomes.

As a community-based organization that has a unique ability to use research to inform its practice, HIM supports the recommendations made by Travis Salway in his presentation. Increasing the availability of access to mental health supports through the expansion of the Public Health Agency of Canada's HIV and hepatitis C community action fund, while increasing research on the health of sexual minorities, will help bolster the work that HIM already does to meet the need for more programming in mental health and substance use.

With the expansion of existing resources and increased capacity, we hope for expanded mental health programming to close the gap in unmet needs. We hope for increased counselling and therapy interventions within our community. We hope for new levels of excellence in mental health care. We hope to both develop and support groundbreaking programs to address forms of addiction that affect our community. We hope to develop higher standards for mental health and addictions care. We hope for a reduction of the stigma of mental illness, addiction and suicide among gay men. We hope to mobilize and engage the community to create a welcoming and healthy environment. Finally, we hope to become a beacon of change and hope for those facing loneliness, anxiety and thoughts of suicide.

● (1600)

In closing, I would like to thank the committee for undertaking this historic study, an important and necessary step toward national leadership in addressing the health needs of my LGBTQ2 health family.

Your leadership in this area will positively impact thousands of sexual and gender minority lives for years to come, and I thank you for that.

The Chair: Thank you very much.

I hope we make progress.

Now we go to Mr. Coolman.

Mr. Tristan Coolman (President, Pflag York Region): Thank you very much, Mr. Chair.

Good afternoon to all of you. My name is Tristan Coolman. I use the pronouns he, him, his, and I identify as a gay man. My journey with volunteerism led me to my current position at Pflag York Region as its president. Pflag York Region is a support, resource and education network for all municipalities in York region.

It truly is an honour to be here today to speak directly to LGBTQ2 + health in Canada. With Pflag, we have a variety of initiatives that promote community and safe spaces. For example, we host several coffee nights a month, which act as support meetings for LGBTQ2+ identifying individuals, their families, friends and allies. It's a safe, confidential space to share their stories and gain advice from others who are on similar journeys. We are family for all, where no hand goes unheld, where no one is left behind.

I encourage all of you, as members of this standing committee, at some point to attend a local Pflag meeting in your respective ridings. It's one thing to allow me to speak today, and my colleague from Toronto, in February, just to share a small handful of stories, but it's another to hear them in person.

LGBTQ2+ health, as I'm sure you have discovered, varies immensely based on a number of intersections, which can include but are not limited to access to education, income and financial stability, ethnicity, creed, faith and geography. You name it, and it will change and shape that person's experience.

As a gay man, I've experienced intersections with my background. I was raised by an immigrant single mother. With her background and upbringing from Guyana, her influences from my grandmother and her siblings, she didn't know much about the LGBTQ2+ community. When I came out almost 15 years ago, neither did I. I came out on Labour Day in September 2004, as I entered my last year of high school.

I recall the moment when I knew things would be all right. I had received an essay back in my Canadian law class on the legalization of same-sex marriage in Canada—quite the hot-button issue back then. It was one of the easiest essays I had ever written. As I received my paper back, I looked down and saw a mark of 98%, easily the best grade I ever received. My teacher handed it to me with a smile and invited me to drop by the office during lunch. I did, and I was greeted by my philosophy, history and economics teachers, all of whom shared how impressed they were with the paper and wanted to congratulate me.

That support meant everything to me and gave me the courage to confront my mom. That night, I knocked on her bedroom door and handed her the paper without saying a word. A few days later, we embraced and talked it out. There was still work to be done with our relationship, but in the moment, I knew it had pivoted in the right direction.

Fast-forward to today—15 years later and 50 years since homosexuality was decriminalized in our country. I wish I could say I hear more stories like this, but I don't. The situation is dire. A lack of education and a lack of understanding and love for one another are still running rampant in our communities from coast to coast to coast. Unfortunately, hate is alive and well, compounded by a lack of access to services, degrees of homophobia, transphobia and queerphobia that are layered into each intersection in our country. It is institutional, it is cultural and it's once again gaining strength in numbers.

One of our service users who identifies as a transgendered woman has faced consistent discrimination in every work environment she has entered. She works in construction and has an exceptional skill set as a manager. However, on every job site she has worked on, she's been faced with hateful comments in verbal exchanges with her co-workers and in private, etched on the walls of bathroom stalls.

Recently, she encountered a time of financial instability. She shared that she had to move as she was being evicted due to missed rent payments. She had to make a choice between paying her rent and paying for her meds. She shared this news in December 2018, and we've yet to hear from her since.

Clearly, more needs to be done to encourage our private sector partners to engage their employees in equity and inclusivity training.

Very recently, a mother and her son started coming to our meetings. Soon after, the son shared that he was struggling with his gender identity and started to identify himself as non-binary. The mom and her child are in their mid-fifties and late twenties respectively. They were diagnosed with Asperger's and anxiety. As they started to seek other support services, the mother shared her experience in contacting a number of clinics and counselling services. With a referral, wait times to even meet with a professional were at least five months. Services, however, could be accessed quicker; they would just have to pay for them. Unfortunately, the family cannot afford the luxury of receiving quicker access to counselling services.

For some, counselling services wouldn't mean just an improvement in their quality of life; it could very well be the key to unlocking how they navigate their gender identity. It may be the key to unlocking how they navigate day to day and how they choose to present themselves to the world and mark their place in it. It may be the key to unlocking how they can live as their true, authentic self.

● (1605)

We recently met with a family of a transgendered boy who has fears that many of us in this room have thankfully never experienced. One day the family—mom and son—were at a local community event attended by hundreds of their friends, family and neighbours. Everyone seemed to be having a good time until mom had to use the washroom. It was a hot summer day, so they'd had a lot to drink to stay hydrated. The only washrooms available were in a nearby community centre. When mom asked if he needed to use the washroom, her son said he'd wait until they got home. It would be hours until they would get home.

Her son then shared his feelings on using public washrooms. He described that using a separate, gender neutral washroom in the presence of a male and female washroom would feel like an act of coming out. Her son is still very conscious of his appearance. He cut his hair short and started wearing larger and darker coloured articles of clothing to look, in his eyes, more like a man. Conscious of his appearance, he fears for his safety when using a male washroom. He feared strangers taking notice of his actions and his appearance. He feared strangers who may want to question him in person and who may even turn violent. Just imagine that every time he goes to school, or goes out with his friends or his family, he's exposed to situations that threaten his perception of safety.

For many in the LGBTQ2+ community, safety and health work in tandem, with personal safety being a daily concern. Much like a soldier in a war zone, people like this young man are incredibly conscious of threats to their safety. On the surface, sources of these threats can sound simple enough, but the roots are largely cultural and could be mitigated by the way we think about equity, diversity and inclusion in all of our institutions at all levels of government.

Allyship is not an identity, but a set of behaviours and character traits we all need to promote. It's a lifelong journey of connecting with marginalized groups and individuals to build trust and hold those who threaten these groups publicly accountable, with no room for interpretation. Most importantly, being an ally isn't something you get to call yourself. It's a title that's earned.

Allyship can take many forms. Being an ally can take the form of identifying pronouns in everything you do—from a signature on an email to introducing yourself with them in a formal setting like this meeting here today. Sharing your pronouns makes those who identify with a gender and those who don't feel welcome and openly accepted.

The LGBTQ2+ community simply doesn't have access to the same quality of life as the majority of Canadians highlighted earlier, with months-long wait times for services. Unfortunately, this access greatly depends upon the moral fibres of our leaders. The LGBTQ2+ community expects each and every one of you, regardless of political party, to evaluate and understand the recommendations you've heard so far and any that are brought to you in the future. You must push forward with all of them with the utmost urgency. It's not your place to pick and choose, but to listen and to take action.

There is no boundary—and there should be no boundary—between levels of government. There is no excuse. It is no exaggeration for me to sit here today and to say that LGBTQ2+ people are at a disadvantage. They're alone. They are suffering. They are dying. They have died. My first boyfriend was one of them, having lost his battle with depression at the age of 23.

I want to make my personal recommendation clear to all of you. I expect you and your colleagues, both past and present and across political boundaries, to lead by example and to take on the life of being a strong ally to marginalized groups like the LGBTQ2+ community. Leave no room for interpretation when it comes to the use of hateful statements and actions, whether they are direct or ambiguous. It is simply not enough to assume you or your colleagues possess these characteristics. Fifty years have gone by since homosexuality was decriminalized and we have not moved fast enough.

● (1610)

It was the allyship of my high school teachers that gave me the courage to confront my mom. These behaviours may have saved the life of my first love. They would have stopped discrimination on that construction site. They can make our community spaces institutionally accessible and access to health care services more equitable. Should this committee suddenly dissolve, it is allyship that will carry this cause on. The lens of allyship requires no bills and no second or third readings. It's allyship that will truly hold us accountable to future generations of LGBTQ2+ people in Canada.

Thank you.

The Chair: Nice work. You have one second left.

Mr. Tristan Coolman: You may have noticed that I shortened it a little bit.

The Chair: I looked at him and said that he's not going to make it.

We have five pieces of committee business to do. We can go until five o'clock and then we have to switch to committee business in camera.

We're going to start the questions right away with a seven-minute round with Mr. McKinnon.

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

Thank you all for being here today.

Dr. Salway, you spoke of conversion therapy as a major problem and recommended that it should be banned.

First, I'd like to understand who is performing conversion therapy?

Dr. Travis Salway: That's a great question.

Historically, mental health professionals, including psychologists and psychiatrists, practised versions of conversion therapy. Homosexuality was, up until the late 1960s, considered a mental illness. There are some roots of it in the mental health profession, but since that time we've seen a dramatic shift in all of the major bodies of psychologists and psychiatrists saying not only is homosexuality not a mental illness, but there is actually a way forward if we offer sexual and gender minority-affirming counselling approaches. For the most part, those health care professionals and mental health professional bodies are self-regulating and are encouraging their members to offer therapeutic practices that are affirming of sexual and gender minorities.

As for where the practices are happening, it seems to be primarily outside of health care settings in Canada or sometimes across borders. In some cases, people might be sending their children, youth and adolescents to camps in the United States. In all of these cases it's been performed by either health professionals who are largely considered to be operating out of sync with guidelines or by non-health care professionals. In some cases these might be leaders in communities of faith or they might be providers who are no longer respected or licensed.

● (1615)

Mr. Ron McKinnon: In general, the practice is discredited amongst mental health professionals at this point.

Dr. Travis Salway: That's correct.

Mr. Ron McKinnon: The people who are performing these practices—I hesitate to call them therapies—are third parties. Are these people doing this for hire or for profit?

Dr. Travis Salway: Yes, that happens in some cases.

Mr. Ron McKinnon: You mentioned also that in some cases, maybe many cases, people subjected to this feel compelled.

Who gets compelled and how are they compelled?

Dr. Travis Salway: I think the most typical scenario would be a minor who's living under guardianship. Their parent or guardian might be concerned when their child expresses a form of distress or starts questioning their gender or their sexuality. At that point you might imagine—given what we've talked about—that a parent who feels unaware or maybe unconnected to resources like Pflag, or a parent who feels unsure of whether their child can have a happy, healthy life as an out LGBTQ2S person might feel drawn toward one of these programs that falsely promises a different way forward in the form of conversion.

It's my understanding that this is typically the scenario when someone is being brought to the programs. There is a large and growing community of survivors of conversion programs in Canada. I've spoken to several of them in the last few days. Generally, their experience is that there's is a range of discomfort through to trauma in these programs. Very often they find their way out of the programs and find other forms of support through organizations like the ones that have given statements today. In some cases, unfortunately, they do not because there is a lot of internal pressure put on people who participate in the program. It's probably well-meaning parents, but in the absence of other resources they are turning to these practitioners —for lack of a better word.

Mr. Ron McKinnon: In terms of banning this practice, I would be interested to know if you've given some thought as to what mechanism the federal government might use. As a medical practice it would be in the purview of the provinces. Do you envision this as something that needs to be added to the Criminal Code?

Dr. Travis Salway: Yes.

The countries I am aware of that have done this are Malta and Taiwan. The risk in leaving it to provinces to regulate for the health care provider communities is that it pushes this practice into settings that are outside of medical practices. It could be in individuals' homes, in community organizations or in faith-based organizations, and in those contexts, yes, I think an addition to the Criminal Code is required.

Mr. Ron McKinnon: Is this a severe offence that might suggest 14 years, or is it a kind of summary offence that might be two years less a day? What scale of penalty would you seek for something like this?

Dr. Travis Salway: To be honest, I'm not prepared to answer that, but I would say that there are organizations and individuals in Canada working directly with survivors of conversion therapy, most notably including Generous Space, which is a national organization based here in Ontario. They would be able to better describe the severity of the impacts.

In the survey we conducted, most notably we saw the same mental health outcomes we have been talking about. Suicide attempts, suicide ideation, treatment for anxiety or depression and illicit drug use were all higher in those who had attended conversion therapy. The health consequences are quite large. That suggests to me that as an infringement, as an assault, putting someone into conversion therapy, especially youths who aren't able to choose for themselves, is quite a serious offence, but I can't speak to where it falls on that range you mentioned.

Mr. Ron McKinnon: Thank you.

In the minute I have left, I will switch quickly to Dr. Abramovich.

You spoke of homelessness as a major issue. I believe you said that 40,000 LGBTQ youths are currently homeless.

● (1620)

Dr. Alex Abramovich: It is 25% to 40% of those youth, yes.

Mr. Ron McKinnon: Okay.

I'm struggling to understand how parents can do this. How can they expel their loved ones like this? I don't grasp this. Could you give me some insight?

Dr. Alex Abramovich: Sure, absolutely.

It's really tough to wrap your head around this, absolutely, especially given how high the rates are.

We know that family conflict is the number one cause of youth homelessness across the board, regardless of a young person's identity, but for LGBTQ2S youth, it has to do with identity-based family conflict. For a lot of these young people, perhaps they were living in a home where there was family conflict for years, and then as soon as they came out as trans or lesbian or gay or bi, it came to a situation where either they were kicked out or were forced to leave home because of the conflict. It's really about identity-based conflict when a young person comes out. That is the leading cause.

The Chair: Okay, we have to move to Ms. Gladu now, for seven minutes.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair, and thank you to the witnesses.

I'm going to start with Alex.

You talked about a program that was in place in Toronto at the YMCA's Sprott House.

Dr. Alex Abramovich: Yes.

Ms. Marilyn Gladu: Can you describe what that looks like and how it's different from what everybody knows as the YMCA?

Dr. Alex Abramovich: Yes, absolutely.

Sprott House is a 25-bed facility. It's a transitional housing program. It's more of an independent-style housing program. It's not an emergency shelter. If a young person has just been kicked out of the home, finds his or her way to Toronto and needs a place to sleep right then and there, that's not what Sprott House offers. You have to apply for the program. You have an interview, and then you come to the program. It's not as quick as an emergency shelter. There are currently no emergency shelters for LGBTQ2S youth.

Young people can live at Sprott House for up to two years. They have case management and a variety of different life skills programs that young people are able to attend. All of the staff who work there are either LGBTQ2S-identified or have a very strong understanding. They have received quite a bit of training.

All of the programs they have designed are really focused on an LGBTQ2S lens. For example, the forms that are filled out when a young person enters a shelter or a housing program generally do not include LGBTQ2S youth, but that's a difference at a place like Sprott House where everything is really done with the idea of LGBTQ2S youth at the centre of all the services, all the forms, everything they offer.

Ms. Marilyn Gladu: Okay, very good.

Did I understand you to say that there are 40,000 homeless LGBTQ folks across the country?

Dr. Alex Abramovich: No. There are 40,000 young people experiencing homelessness across the country, and 25% to 40% of those youth identify as LGBTQ2S.

Ms. Marilyn Gladu: Okay, very good. Thank you.

Greg, I want to talk about your comment that if the STI clinics had mental health supports there, people would feel comfortable to talk to them. What kind of mental health supports are you recommending, and what's the state of the nation in terms of the number of STI clinics across the country?

Mr. Greg Oudman: Health Initiative for Men operates five health centres throughout the Lower Mainland that provide HIV and STI testing. We've developed an integrated approach at our health centres where access to our mental health programming, which I've described as well, is available through those health centres. I believe Travis undertook a study that included the health centres that Health Initiative for Men operates, as well as some other STI clinics in the Lower Mainland, and found that 28% of the respondents identified as having an unmet need, and 83% of those identified as being open to accessing mental health programming.

I think what we saw through that study was that because STI clinics are already in existence, it's a perfect opportunity to expand the purpose of those health centres or those clinics to potentially provide access to mental health supports through those health centres as well. We've done that within our five health centres in the Lower Mainland, and the response has been overwhelmingly positive.

● (1625)

Ms. Marilyn Gladu: We heard this same comment when we visited the Nine Circles clinic in Winnipeg.

You talked about queer-focused suicide prevention. How is the suicide prevention training different from what would be suicide prevention training rolled out across the board?

Mr. Greg Oudman: Actually, I'm going to see if Travis would speak to that because that's his area of expertise rather than mine.

Ms. Marilyn Gladu: He was my next stop anyway, so sure.

Mr. Greg Oudman: I can speak about it a little bit.

You've heard mention both today and from the other presenters who have spoken to your committee about the specific, unique needs of LGBTQ-identified folks. I think those same unique needs also apply to the sphere of mental health. We have found, again through research and through practice, that suicide prevention programs that have a specific focus on LGBTQ2 folks, even in terms of increasing the level of competency among mental health service providers in terms of their counselling, have proven to be more effective.

Ms. Marilyn Gladu: Travis, do you want to chip in?

Dr. Travis Salway: Yes, absolutely.

Of course, suicide in particular and other mental health topics as well are stigmatized for everyone. There is a reluctance to open up. There is a reluctance to confront it head-on. You might imagine that for folks like sexual and gender minorities who have a history of feeling the need to hide, conceal or withhold, you have a double layer of stigma. What this means is that both where we end up, in terms of migrating to communities that are more sexual or gender-minority affirming, and where we turn up for services will look very different. This means that sometimes we need tailored strategies.

I work as part of a study team in Vancouver called Still Here. It's a study of experiences of suicide with LGBTQ2S people. It's led by my colleague, Dr. Olivier Ferlatte. In that study we found that when we actually did photo exhibitions with art-based approaches and got LGBTQ2S people together, there was a little more comfort in talking about the levels of suicide in the community.

Apart from those spaces, or apart from queer-focused or queer-affirming suicide prevention services, there is a tendency to want to withdraw, to be reluctant. In fact, when we talk about some of these statistics within LGBTQ2S communities, often people are either surprised or want to shy away from it, maybe because they feel like there's already a point against them, and they don't want to be doubly stigmatized.

Ms. Marilyn Gladu: Right, but do you think that people would go to suicide prevention if it were—I don't know how you'd call it—a queer-oriented suicide prevention? Would there not be fear, for those who are afraid of coming out and all that kind of stuff?

Dr. Travis Salway: Yes. The way to deal with that is to have that training led by organizations with strong histories of doing good work with queer communities.

You're right, though. We need both approaches. It won't reach everyone, so we need a general suicide prevention approach—a universal prevention strategy and a targeted strategy. With both of them we would hope to reach the people who need them.

Ms. Marilyn Gladu: Thank you.

The Chair: Thank you very much.

Now we go to Mr. Davies.

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

Mr. Coolman, we were in Calgary, and I was struck by the words of one of our witnesses. He said that he hasn't come out once; rather, he has to come out 10 times every day. He was talking about the fact that every time he or friends of his in the gay men community intersected with the health care system, there was always this trepidation or feeling that they had to reveal something. In particular, he said that once it was revealed that they were gay, they were often asked stereotypical, assumptive and presumptive questions that were actually inappropriate for the malady they were presenting with.

Do you have anything to tell the committee about that?

Mr. Tristan Coolman: Yes. It makes me think of a story that was shared with the committee in February of someone who went to a clinic and asked for their chosen pronouns to be used. They weren't used and they were not respected.

There is a variety of reasons this could be happening, whether it's a lack of respect for the community or for how people identify themselves. The motivations behind that are 100-fold. That's why I spoke to allyship today. It's because those behaviours really shape how you interact with anyone in your daily life. That's something that really needs to be promoted. In addition to all the recommendations we talked about today, those behaviours are really what are going to drive change.

● (1630)

Mr. Don Davies: Is the experience you described common?

Mr. Tristan Coolman: Oh yes. For me, I come out every day at work. I'm an IT professional. I take appointments to fix people's devices. Once a day there's someone who asks me if I have a girlfriend or kids. I come out unabashedly to them to prove the point that there's really no reason to assume that nowadays.

Mr. Don Davies: Thank you.

Mr. Salway, you come from Vancouver and the Lower Mainland, and I represent Vancouver Kingsway. Of course, we know it's a very ethnically diverse and very rich cultural mosaic in the Lower Mainland. I'm just wondering if you have noticed in your research any special considerations that have arisen from having a multiplicity of cultures come together.

Dr. Travis Salway: Yes I have, absolutely.

Tristan alluded to this when he talked about the effects of intersections of multiple social positions.

Since my work has mostly focused on suicide, I'll comment on one that really stands out. That is the experience of indigenous Canadians, who also experience a rate of suicide four times greater than the non-indigenous population. Not surprisingly, indigenous sexual and gender minorities experience both of those forms of oppression, stigma and historic injustices at the same time.

Very often in health care—and maybe in a lot of our institutions—we think of one population at a time, so the people who fit in those intersections often get left behind. When we talk about a queer-focused suicide prevention strategy or queer-focused services, sometimes that implies we mean it primarily for individuals who are part of the white majority, and that's unjust. For that reason, I would encourage the committee to invite speakers who have expertise working with indigenous and two-spirit LGBTQ people.

Mr. Don Davies: My friend Mr. McKinnon talked about conversion therapy. There was a recent petition tabled in the House by my colleague from Saskatoon West, Sheri Benson, calling on the federal government to amend the Criminal Code to ban conversion therapy.

That request was rejected by this government. The reason given was that this was largely a provincial and territorial issue and the practice can already be addressed through existing provisions of the Criminal Code, for example, kidnapping, forceable confinement and assault.

In your view, does this answer satisfy you, or would you like to see an explicit Criminal Code provision to ban conversion therapy? Do you feel that the current Criminal Code is strong enough in its present form?

Dr. Travis Salway: I do not, and the reason is the practice itself is very hard to categorize as one of those offences that you mentioned. Very often, the practice is a little subtler in how it's initiated, but in a way, it's more pernicious because it goes on, sometimes for years, sometimes for months, and the effects last for decades.

I believe it needs its own category of criminal offence. I'm not sure if I'm using the right terminology. I disagree that the current situation is sufficient, in particular with regard to health providers.

Mr. Don Davies: Thank you.

Mr. Oudman, I know that Health Initiative for Men provides services primarily to gay men. Are your services also available to bisexual, transgender, two-spirit, or other men who have sex with men?

Mr. Greg Oudman: Yes, definitely. We use the term "gay", but we use it in the broadest possible sense. We're engaging in a process organizationally where we're looking at that definition and looking at how we present ourselves. We talk about the GBT2Q group of individuals that we work with, and definitely we know that guys who attend all our programs, whether it's our health centres or our social, physical or mental health programs, identify across the entire spectrum.

Mr. Don Davies: Do you see any differences in the mental and physical health needs of those different populations, say, between gay men and compared to bisexual, transgender, two-spirit men?

Mr. Greg Oudman: No, I think we see that for gender and sexual minorities generally the presenting issues are typical. My colleagues prior to me spoke to the marginalization that people who identify as a gender or sexual minority identify with. We see those issues across the board in all the individuals we work with. No, I wouldn't say there are significant differences among those categories.

● (1635)

Mr. Don Davies: Thank you.

Mr. Abramovich, in your view, should the federal government develop a Canadian sexual health promotion strategy that would provide comprehensive information on sexuality and sexual health and encourage its use in school curriculums across the country?

Dr. Alex Abramovich: What would that look like, exactly?

Mr. Don Davies: I was hoping you would tell me.

I guess the idea is gender and sexual identity emerge at very young ages, and I'm not sure that our school system in this country is responding at a young enough age to give positive expression to kids when they're first starting to experience their gender and sexuality. I'm wondering if you'd see a role for the federal government in helping.

Dr. Alex Abramovich: Absolutely, I think that's really been missing, especially with the population I work with.

A lot of these young people are quite young when they come out. They're still in school, and their families are not prepared to deal with and to support them and they don't have the resources. I think many of these families would want to support their young person, but they don't have those resources. They don't have the tools. They don't have the education. I think there's a place for the education system to help those young people when they come out. They're in school. They're coming out. They're living with their families. I think there's a place for a lot more support in that type of a situation.

The Chair: Now we'll go to Ms. Sidhu.

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

We heard a lot about LGBTQ2. My colleague Don Davies just pointed out you're facing lots of discrimination in the health care system. What kind of education on inclusive training is needed in the health sector? You said that at YMCA Sprott House they're giving inclusive training to staff. Do you think you need some type of training in the health sector? What kind of training needs to be done?

Dr. Alex Abramovich: Yes, absolutely, I think that's a very good question and a very important point.

Currently in medical school there is really no training around LGBTQ2S awareness or inclusion; that's really lacking. Perhaps they might sometimes have a guest lecturer, but that might not happen for everybody. I do think this needs to be part of the curriculum. It is extremely important, given the issues around access to health care, especially for transgender individuals.

One of the comments made me think about a lot of transpeople who, for example, might end up in the emergency room for an ear infection, and somehow the physician finds out that the person is trans. All of a sudden there are inappropriate and invasive questions that have nothing to do with the ear infection. I think that's a common experience for a lot of transpeople, unfortunately. I believe that with more education and training perhaps we could avoid situations like that in the future.

Ms. Sonia Sidhu: Thank you.

Dr. Salway, re lack of education, what kind of tools are needed to educate our kids in the schools and at what age?

Dr. Travis Salway: I would agree with everything that Dr. Abramovich said. I think we need more education about providing sexual and gender-affirming care at multiple levels, so I think it can begin in the schools so people can have an early general sense of the power and the sense of self-confidence that comes from acknowledging and embracing diversity in sexuality and gender.

Then, yes, we do need these very highly trusted, really critical gatekeepers, whether they're health care providers or teachers. They need to understand as well, and we need to catch them up so they understand how not to ask questions that will then deter that person from seeking care again. We know from the work Greg Oudman referred to that in the sexual health clinics and in the community-based organizations we have people showing up for concerns that aren't necessarily specific to, let's say, HIV or sexual health. That's because there's a feeling of trust there.

I think we can learn from organizations like his, from other LGBTQ2S organizations, on how they've created safe and inclusive environments, and create standards or guidelines that would then transfer to other health care settings across the country.

● (1640)

Ms. Sonia Sidhu: What do you think is the best age for kids to know about sexual health?

Dr. Travis Salway: That's beyond my area of expertise, but the earlier the better.

Dr. Alex Abramovich: I think as early as possible, so perhaps even in preschool we can start talking about identity in different ways.

Obviously, the way you explain this to a child in preschool would be quite different, but if you look at the books that are offered in day cares and in preschools, a lot of them are quite heteronormative and cisnormative, so a lot of times the examples that many of these teachers use are examples of families that have a mother and a father, and those are the only examples they have. For example, I have a child in preschool and the comments are really heteronormative, so if she makes friends with a little boy, all of a sudden that's her boyfriend, but if she's friends with a girl, that's her best friend.

I think that education piece can start very early because we're modelling that to really young children. Many LGBTQ2S books are available for children as young as preschool, and they're brilliant. I believe those books should be available in the school system.

Ms. Sonia Sidhu: Thank you.

What recommendation would you make to ensure the online or telephone intervention methods are effective in preventing suicide attempts? Do you think online is—

Dr. Travis Salway: Absolutely, I think as we move forward we need online and offline approaches. I think that's the best way to reach the maximum number of people. I have experience working in a crisis centre, and there we found a very different type of person will reach out online for support. I think it holds a lot of promise for people who are living in a rural and remote region, so I think we need both. Similarly, at the end of the line, there is still either a source of information or a counsellor. There's someone you need to create an environment of trust. We still need LGBTQ2S-inclusive approaches to those interventions as well.

Ms. Sonia Sidhu: Why is there the high rate of problematic substance use in gay men? Is it the homelessness?

Dr. Travis Salway: One research model that Greg alluded to as well is the syndemic theory. Syndemic theory suggests that the reason we see multiple health problems arise in the same population —and you mentioned substance use, but we could also talk about anxiety, or many of the other health issues we're referencing today— is a confluence of two things. One is a history of feeling stigmatized and feeling different. Sometimes when those feelings get internalized a form of coping becomes substance use. It also becomes a way to connect to other people.

In syndemic theory one of the suggestions is that these populations will get together in the same geographic space. That's what has happened historically with gays and lesbians and other sexual and gender minorities. We've gathered together in certain places so we could connect with one another in community. That means sometimes if there's already a high rate of substance use, that becomes a form of connection. It also decreases inhibitions. If I've been told all my life that my sexuality is wrong, I might feel a natural rejection when I see another man, but using substances helps to relieve some of that inhibition and some of that fear.

The other piece of syndemic theory is that because these populations or these groups who disproportionately experience these health outcomes may have been excluded historically from some health services, as we were discussing today, it just might take a little extra effort to reach them and bring them through the door, given that they might avoid going to the ER or they might avoid going to a health clinic because they're not quite sure how that provider is going to react to their sexuality.

The Chair: Okay. The time is up.

Now we're going to go to our five-minute rounds, starting with Ms. Gladu.

Ms. Marilyn Gladu: I'll start with a question for Tristan.

I apologize for my ignorance, but you had referred to non-binary people. I didn't know what that was, so I asked my colleague and he didn't know either.

What is a non-binary person?

Mr. Tristan Coolman: That's why we're here, to help educate you all.

Someone who identifies as non-binary is someone who does not identify as a male or a female, and also would perhaps even present themselves in that way, maybe dress in a little more androgynous manner and ebb and flow with their look as well.

Ms. Marilyn Gladu: Is that the same as or different from asexual?

Mr. Tristan Coolman: Asexual is more of an identity with your attraction to another person.

For a non-binary person who identifies that way, it's more how you feel about how you fit into the world. Someone who is asexual is just someone who does not carry any sexual attraction to anyone.

● (1645)

Ms. Marilyn Gladu: Thank you.

The next question might sound a little risqué, but on our trip, we were in Montreal and they were describing one of the factors, the intersectionality between the gay men population and the drug addiction problem that was there. It was called “chemsex”. I had never heard of that. We talked about it in Winnipeg and they had a different name. You represent across the country, so is this a common thing?

Dr. Travis Salway: I'm looking at Greg. Perhaps he'd like to answer.

Ms. Marilyn Gladu: Greg, we'll start with you, and then we'll come east.

Mr. Greg Oudman: The points that Travis made earlier when he responded to the question around problematic substance use among gay men I think also speak to the whole issue of chemsex—or what's often referred to as "party and play" here in Canada more so than "chemsex". For some of the same reasons that we see problematic substance abuse among gay men, we see gay men engaging in chemsex, or party and play, because it provides a safe space, lowers inhibitions and offers an opportunity for gay men to connect while using a substance.

Ms. Marilyn Gladu: How about Toronto and anywhere else?

Dr. Alex Abramovich: Actually, I can't comment on that.

Dr. Travis Salway: I don't have anything to add.

Ms. Marilyn Gladu: My next question, then, has to do with what I think you, Travis, talked about, the different factors influencing or that people are struggling with in poverty and not having supporting partners. Would you agree that initiatives such as HIM would really help to fill that partner gap that people are experiencing?

Dr. Travis Salway: Yes, absolutely.

If we draw on the first principles of what we know about suicide research and mental health, we know more social supports and more social connections really matter. The reason is that if you're in a low moment when you're feeling quite down, perhaps feeling suicidal, the more people you can reach out to, the better. If you're someone who is LGBTQ2S and you've felt that sense of separation, you may need a place that specifically centres that experience.

Ms. Marilyn Gladu: I have another question about the poverty aspect of this.

I need to understand why we see a greater poverty percentage in this population. My experience is that all my gay friends are rich engineers.

Is it discrimination that's happening in the workplace, or is it that they don't get the education in the first place? Is it the poverty relationship, or what?

Dr. Alex Abramovich: It depends on the subgroup you're talking about. Each group will have different access to employment and education.

I could speak about the people I work with. Oftentimes they may not be able to secure formal employment, because a lot of the young transpeople I work with haven't had their legal name changed. They haven't had their ID changed over, and you need your ID in order to get a job. That creates a lot of really big issues for most of the young people I work with.

As well, if you don't have a place to sleep, it's really hard to get back on your feet. If you're trying to access housing programs, you want to find a place to sleep; you want to find a home. However, you're experiencing institutional erasure, experiencing discrimination, homophobia, transphobia and violence, and you don't have your ID. There are so many things that are coming at you.

Especially if you're a transgender indigenous person, you then add racism on top of that as well. That person would be experiencing even higher rates of poverty and they would have an even more difficult time trying to access secure employment.

The Chair: Now we go to Dr. Eyolfson.

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

Thank you for coming. This is very informative and very helpful.

Dr. Abramovich, I'd like to expand on what you said about the lack of training in the medical system. I graduated from medical school in 1993. The grand total of our education on LGBT issues was little more than "You should be nice to gay people." I think we needed more than that in the way of education.

I'm going to start with Dr. Salway. We talked about the attitudes in society and the stigma that comes with being LGBT, particularly among young people, and, again, even more so in the school setting. Would you agree that gay-straight alliances, GSAs, are a valuable addition?

● (1650)

Dr. Travis Salway: Yes, absolutely. Research that was done in Vancouver led by Dr. Elizabeth Saewyc looked very carefully at school districts over the last 10 years in B.C. that implemented policies allowing for GSAs and found marked reduction in suicide ideation in those schools. So we do have evidence that they're having an effect.

Mr. Doug Eyolfson: Good, and I see a lot of nods around the table as well. Again, I'll say, it was the answer I expected.

There is some controversy, particularly within some political campaigns. Some want to allow schools to have the choice of banning GSAs. Manitoba actually just passed a law saying schools couldn't ban them. Would you feel that any school that receives public funding should be allowed to ban these organizations?

Dr. Travis Salway: I think they are life-saving and I don't think banning them should be allowed. Doing that is denying youth a resource that we know can potentially save their lives.

Mr. Doug Eyolfson: Sure. Thank you.

Further to that, there are those who are advocating that schools should notify parents of children who join these organizations. Would you agree there's a potential for harm in such a policy?

I'll open it up to everybody.

Dr. Alex Abramovich: That is extremely harmful, especially if I think about the population of youth I work with. A lot of these youth need the GSA. They need to have a safe space where they can talk about their identity, and in many instances, that's before coming out to their families, to prepare themselves. If the school were to call those parents, I can guarantee that many of those young people would no longer have a home and we would have an even bigger homelessness epidemic across the country.

Mr. Doug Eyolfson: Thank you.

Now, I don't want to paint with too broad a brush, but we do know there are some faith-based organizations and even some so-called mainstream religions that are still very negative on the subject of LGBT. Would you agree that particularly in areas with large faith-based communities this attitude contributes to these problems faced by LGBT people, the problems of suicide, homelessness and mental health issues?

Mr. Tristan Coolman: I think it really depends on the moral lens the faith leaders have. You have your moral lens and then you have your religious lens, and somehow ideas of how people should live their lives come through the other end.

For example, in our community, in York region, we have a very strong relationship with a lot of our faith leaders there, and we've been to LGBTQ-themed events at local churches. Those leaders see a responsibility to spread the message of love and to make sure that community members don't feel ostracized or don't see the church as a place where they're not welcome.

Dr. Alex Abramovich: If I could add a comment, a lot of the shelters and a lot of the drop-in services for people experiencing homelessness are faith-based. We do have a lot across the country that are run by faith organizations. A lot of the young people I work with have had negative experiences in the past and are more reluctant to actually enter those services, but I do think that many of those services that were perhaps historically homophobic or transphobic can change and have changed, and we've seen those changes.

When they make those changes and they send out that message that they are accepting and they are affirming, and they develop policies or community plans to address LGBTQ2S youth homelessness, that sends out a very strong message, and youth are more likely to enter those services.

Mr. Doug Eyolfson: That's very reassuring to hear.

Thank you very much.

The Chair: Okay.

Now we go back to Ms. Gladu, for a return engagement.

Ms. Marilyn Gladu: Actually, I'm going to share my time with Mr. Webber. I'm going to let him start off.

● (1655)

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

I did miss a bit of Ms. Sidhu's questioning. I apologize if this is a repetitive question.

My question is for Tristan from Pflag.

You mentioned that you meet monthly or weekly. Do you meet in your home? Do you have a community hall? Maybe you could talk a bit about your meetings.

Mr. Tristan Coolman: We first met once a month at a local church. We found that through those meetings a lot of people, to Alex's point, still had apprehensions or past experiences with faith-based organizations and with religion. We've partnered with a couple of other community partners.

We now meet twice a month. We have two spaces. York region, being such a large region, we have one to the south and one to the north to try to serve as many people as possible and to make our services available to as many as possible.

Mr. Len Webber: You kindly invited members of the committee to join a Pflag meeting.

Mr. Tristan Coolman: I highly encourage it.

Mr. Len Webber: Do you invite anyone to come to these meetings?

Mr. Tristan Coolman: They're for anyone, yes. You don't have to be a member who identifies with the community. Sometimes parents without their kids come, without their kids knowing that they're there, because the parents are seeking support, and they are seeking more education on how to approach conversations with their kids and loved ones.

It's free for anyone to attend.

Mr. Len Webber: You talked a bit, personally, about your relationship with your mother during all this.

Do you experience that a lot with people who go to these meetings? Are there a lot of families who cannot accept?

Mr. Tristan Coolman: Last year there was a couple who came and their son had come out while they were on a cottage trip. They were scheduled to be up there for three weeks. He was only there for a couple of days. He came out on the last day and said, “Bye” and just left.

They came to our meeting. The mother was very open about it. The father still had apprehensions and still couldn't really get his head around it. Three or four months later, he was much more accepting, much more loving and caring, speaking up at the meetings and even leading other parents through that conversation.

Mr. Len Webber: That's interesting.

You go into schools. With my familiarity with the curriculum in Alberta, it is very difficult to fit in a lot of issues into a day.

How welcoming are these schools around the country in listening to what you have to say?

Mr. Tristan Coolman: With Pflag, we have quite a few schools who reach out to us every week, every month. With our being a volunteer organization it's sometimes hard to keep up with them. We coordinate with them in terms of what they want us to do, what they want us to speak to. We also share what we would like to share as well.

We ebb and flow a lot with what the schools want to accomplish. Schools more often come to us than we go to them. We are also rebuilding our relationship with the local Catholic school board as well.

Mr. Len Webber: Thank you for what you do.

Mr. Tristan Coolman: Thank you.

Ms. Marilyn Gladu: My last questions are for Greg.

How many men are served by HIM? How much does it cost to run it? You mentioned the Public Health Agency of Canada's community action fund. Do you get any funding from there?

Mr. Greg Oudman: In terms of the number of men who are served by Health Initiative for Men, we operate five health centres. That's our biggest point of contact. We provide supports to about 10,000 men who identify as GBTQ2 in a year. That's within the health centre specifically.

Then I've talked about our services working in the areas of social, physical and mental health as well. We operate a large number of programs that work outside of our health centres. I would say that peripherally we probably reach another 10,000 guys a year via those programs.

I talked a bit in my presentation about doing things like health promotion and knowledge translation. It's hard for us to quantify the reach of those kinds of programs because they are so broad-based. We engage and we do health promotion campaigns that are designed to reach as many men as possible. We find through our analytics that we have people all over the world accessing our health promotion resources that are available online.

We regularly see access to those resources in places that are less LGBTQ affirming than Canada, like countries in Asia and the Middle East. It's really positive for me knowing that while we're a Vancouver or Lower Mainland based organization we have quite a broad range of reach.

That was the first question. Then what was the second?

● (1700)

Ms. Marilyn Gladu: It was about money.

Mr. Greg Oudman: What does it cost? We have a budget of $1.6 million annually that's primarily funded via government sources. Our largest funder is the local health authority here in Vancouver, Vancouver Coastal Health.

We receive money through the Public Health Agency of Canada's community action fund. We never received money from PHAC in the past, but with the community action fund rolling out a couple of years ago, we were able to collaborate with four other organizations nationally. I think you visited REZO last week in Montreal. They're one of the members of what we're calling the Advance Community Alliance. It's a national gay men's health alliance consisting of five organizations that are working to increase access to an uptake of STBBI and HIV prevention technologies.

We receive money there and we also have a collaboration with a number of local organizations that support sex workers, because we also have a significant presence in the Vancouver male-identified sex work community.

The Chair: Good. Thanks very much.

It's five o'clock. I want to ask the committee if we can go 10 minutes extra. That way we can finish our complete round of questions. Is that okay with everybody?

Okay, Mr. Ouellette, you have five minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much.

The 2019 federal budget included initial funding of $25 million over five years to establish a pan-Canadian suicide prevention service. The bilingual service would provide Canadians with access to a service 24-7 by phone, text or chat. In the budget documents, the federal government noted that thoughts of suicide and suicide-related behaviour are disproportionately prevalent among LGBTQ2+ communities, particularly youth, in comparison to their non-LGBTQ2+ peers.

To your knowledge, to what extent are telephone or online intervention methods effective in preventing suicide attempts?

Dr. Travis Salway: It's an excellent first step. Suicide prevention lines are a wonderful way to engage people who are acutely suicidal in a moment of crisis.

What we need beyond that is a place to refer people once they have identified that they have a mental health need and that they're suicidal. The suicidality doesn't always go away; in fact, quite often it comes and goes in different periods of time.

We need to be able to connect them with supports and organizations like the Health Initiative for Men and other services that include mental health providers that are LGBTQ2S affirming.

Dr. Alex Abramovich: I can comment.

We do have some initiatives. There's the Trans Lifeline, and there's the LGBT Youth Line in Toronto. We do have some of these initiatives which are really great. They are certainly used widely. They're under-resourced and definitely used.

I think that oftentimes what happens with these initiatives is they're not evaluated, so it's difficult for us to say how impactful they are or what sort of impact they're having on the community. I find that happens quite frequently with the LGBTQ2S population, especially with housing programs and different initiatives. They're not evaluated, so it's tough to say exactly how they impact the population.

Mr. Robert-Falcon Ouellette: I was just wondering in relation to conversion therapy, how many kids go out of the country. Should it be banned in Canada, having people go outside of the country?

Dr. Travis Salway: I'm not aware of any data. In fact, the sex now survey that I quoted is the only data source that I've found that could quantify exposure to conversion therapy, and we think that's an underestimation, because a lot of folks who are exposed to conversion therapy won't turn up in LGBT2QS community surveys, of course.

Absolutely, it should be banned to expose minors to conversion therapy wherever it's taking place, even if it's overseas.

Mr. Tristan Coolman: I can make a quick comment on conversion therapy.

There have been some comments made today about it being out of the scope of the federal government. One thing I want to mention is that, if you leave it up to the provinces, you're creating your own inequity with it. Everyone needs to play by the same rules. A federal ban is going to reinforce that support for the community and hold everyone who practices this fraud accountable.

● (1705)

Mr. Robert-Falcon Ouellette: I was wondering if anyone could comment on health outcomes for people who are lesbian and issues that they face in the health care system.

Dr. Travis Salway: I can briefly speak to what we've seen in the Canadian community health survey, which are higher rates of the mental health outcomes we talked about affecting lesbian and bisexual women than heterosexual women.

There is ongoing research in the United States that suggests that sexual minority women are at higher risk for some physical health outcomes. We don't have the data here in Canada to evaluate that. For instance, the Canadian community health survey only asks sexual orientation for people up to age 59.

We do have other physical health surveys, like the Canadian health measures survey, but they don't include measures of sexual orientation or gender identity. It very well may be that some of those physical health ailments occur at higher rates in lesbian and bisexual women, but we don't have the data to show it.

Mr. Robert-Falcon Ouellette: I just have 30 seconds, I think, by my own calculations.

How should we collect that data? Who should be collecting that data?

Dr. Travis Salway: I would start with Statistics Canada because it has several national surveys that measure health-related outcomes. I think there's already work under way, but it could broaden the consultations to understand what specific measures should be added. There need to be, as we've alluded to, multiple measures.

Dr. Alex Abramovich: Yes, I would say that any of the health surveys that collect demographic information should be collecting this data. In any survey that has the question of male or female, we have to actually add more inclusive gender identity questions, as well as sexual orientation questions. I don't think it's just one.

The Chair: Now we go to Mr. Davies.

You have three minutes.

Mr. Don Davies: One thing that I'm hearing loud and clear is that stigma and discrimination is a serious problem in the LGBTQ2S world. We know there's a ban on blood donation by men who have sex with men, and there doesn't appear to be any valid scientific basis for it. I know there was a promise by the Liberals in the last election that they would eliminate the five-year ban. They have not done that. They've reduced the five-year abstinence period to one year, which I've been told is ridiculous. It's ridiculous to expect men in a monogamous gay relationship to abstain from sex for a year as a condition to giving blood.

I'm wondering how you feel, as gay men, about that issue. Does it bother you that we have official government policy that essentially discriminates against people? We know that there could be a heterosexual man who engages in extremely dangerous practices, and there's no automatic ban on his donating blood. How do you feel about that?

Mr. Tristan Coolman: Myself, I'm thankful to work in a really amazing work environment where we encourage blood donations. We just celebrated the one-year anniversary of our partnership with Canadian Blood Services, but every time an event comes up, I'm left out. I know that I can't donate, and although I'm happy for my colleagues to go out and donate, it's very frustrating for me to not be a part of that and not be a part of the great work that Canadian Blood Services does and the many lives that it saves through that work. I want to contribute, but my government tells me that I can't. It's very disappointing.

Mr. Don Davies: I'm going to leave the last word to you. Each of you, if you were the prime minister, what's the one thing you would do if you could do anything to improve the health of the LGBTQ2S community?

I only have three minutes, so you have to be quick.

Greg, what would be the first thing you would do?

Mr. Greg Oudman: I think a quick win would be to encourage the development of a national strategy, a national LGBTQ2S health strategy that streamlines approaches to LGBTQ2S health. It would look at what the drivers to compromised health are and then develop a streamlined, comprehensive approach rather than piecemeal approach.

I think my colleagues Mr. Salway and Mr. Abramovich have spoken about the need for increased research. I think those are quick, easy wins as well, like adjusting the surveys that Statistics Canada already operates to be more inclusive and to gather more useful information that will help an organization like Health Initiative for Men, as a grassroots community-based organization, use that research to inform its practices.

Mr. Don Davies: Prime Minister Abramovich.

Dr. Alex Abramovich: I would like to speak to the work that I do. Something I feel very strongly about is a national strategy on addressing and ending LGBTQ2S youth homelessness across Canada. That would involve working with provinces across the country to develop specific plans for each province that would address this issue and prioritize this population of young people so that we develop inclusive and supportive programs and housing programs, as well as health centres and increased training, working within the school system and working with families so that young people are not kicked out of their homes when they come out.

● (1710)

Mr. Don Davies: I think I'm out of time, so you'll have to wait until the next election.

The Chair: Thanks very much.

Mr. Davies asked what you would do to best help your community if you were prime minister. I think the best thing that you could do is send all Canadians on the same trip that we made last week. We learned so much. I was sitting here thinking, “What is the emotion that I feel?” The emotion that I feel is a privilege to see and hear what we heard last week and today. We heard the most intimate, personal issues that we don't usually hear. I came back from that trip —I think we all did—really moved and humbled by it, so if I were prime minister, I would send everybody in Canada to go do what we did, if they can survive it.

Anyway, I want to thank all of you for your participation. It's been very helpful.

I know, Mr. Coolman, from your opening remarks that you're in a hurry, but this place doesn't move fast. However, it's progress. I believe you're making progress, and things like this make a difference. It will help.

Thank you on behalf of the committee.

We're going to break for a few minutes, and then we're going to go in camera.

[*Proceedings continue in camera*]