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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call our meeting to order.

Welcome to meeting 141 of the Standing Committee on Health. We'll continue our study on LGBTQ2+ issues for health.

We're very pleased to have with us today Dr. Tinus Wasserfall, who is presenting as an individual.

From Diversity ED, we have Crystal Fach, and in absentia, Adam Gariepy, who will be along later. We're not sure.

From Kelowna Pride Society, we have Dustyn Baulkham, general manager.

From Pflag Canada, we have Loretta Fearman by video conference from Barrie, Ontario.

Welcome everyone. Each organization will have 10 minutes for an opening statement.

We'll start with Dr. Wasserfall.

Dr. Tinus Wasserfall (Family Doctor, Spectrum Health, As an Individual): It's a pleasure to be here, and thank you all for your time.

I would like to introduce myself. I'm a family physician who has spent most of my career devoting my time to delivering health care to the LGBTQ community as well as people living with HIV. This is a very important topic to me.

I'm also here as a gay married man. I'm here as a doctor, but I've also been in the health care system as a patient, so I'd like to tell my story and get some points across on what I think is important on this topic.

I'm sure that in this committee you've heard a lot of the salient points regarding LGBTQ health care, so I thought I would just tell you stories. Hopefully, these stories will get some points across and maybe offer some solutions to what I think are the issues. I'm going to tell you patient stories. There's no personal identification in these stories, so it's all confidential. I'm going to see how much time I have to see how many stories I can tell you.

The first story I want to tell you is about a patient of mine who was distressed because his friend, a female patient, was really struggling in the health care system. She really needed a doctor. I agreed to take her on as a patient and in comes this lovely, let's say, mid-fifties, female patient, and she is a female-male transgender woman. She comes in with a bit of trepidation. I can see she's a little bit anxious and we start to talk, do a bit of introduction, and then I tell her about what we do at my clinic—what we've done for 20 years—and that we call it a medical home for patients, but a medical home specifically tailored for LGBTQ patients.

We have low barrier access. We're very respectful, staffed from top to bottom, and very aware of what this group of patients needs and how to communicate with them. We're a multidisciplinary group, doctors, nurses, pharmacists and other staff.

I started to talk to her. I said, “This is your new medical home. You will always be safe here. You will always be heard. You will always be respected.” In those few seconds that we spoke, I saw a ton of bricks falling off of her, that relief. I suspect she experienced a lifetime of prejudice, and in the medical system, not always having optimal communication and being asked uncomfortable questions.

That's my first point. What's important is that this population needs a medical home that's tailored to them. We can talk during question period about what that means, because in today's day and age, medical home doesn't necessarily need to be a specific physical place.

I have one more point to make about her. She's a happy patient, happy in her new medical home where her needs are met. She has to go for a routine colonoscopy. She goes to our local hospital and I get the report back, and my heart sank, because the report said that a 56-year-old male patient was seen and he was told this and that. My heart just sank, because I actually knew the people, those physicians, and they're great people, but there's a systemic problem in how medical professionals get educated around LGBTQ health issues, and how they communicate. If you ever met this woman, you would never refer to her as a male, and that was an atrocity.

● (1535)

So often, and I don't know if this is across the whole country, medical education for health care professionals around this issue is either an opt in or non-existent. My second point is that I really think that “mandatory” sounds like a prison sentence, so I don't want to say that word, but I think we really need to have it in medical education for health care professionals on all levels as a really important issue that's strongly encouraged, but I don't want to say “mandatory”. That's my first story.

My second story is about doing scoping for anal cancer. Although I'm a family physician, I trained in that. I see a 46-year-old gay man. He came in and said, “I've had complaints for a long time, a few years. I've seen a few doctors, and they told me I have a hemorrhoid.” I looked with a scope, and sure enough, unfortunately, he has anal cancer, which is quite a devastating cancer diagnosis. It's treatable, but the treatment is harsh.

Why I bring this up is that in the gay population, anal cancer is a much more prevalent cancer than in the general population. There is screening available. There are clinics like mine also available in Vancouver, but they are minimal. I think, if I would make a recommendation, I would say that gay men need to be screened for anal cancer and need to have access to clinics like mine, where I work, to be assessed and to make sure that, even if they have cancer, it's early cancer that can be treated.

Women are the same. Cervical cancer rates, actually, are the same as anal cancer rates for men who have sex with men, so it's the same thing. All women have universal access to screening in colposcopy clinics province-wide, probably country-wide, but gay men don't have this. I think that's a very, very important point, as I said, in looking at gay men's health.

This is my next patient's story. I got called by a health care nurse. A 24-year-old guy just got diagnosed with HIV. It was very distressing. It was in the past year or two. He came in. He was in school and was devastated by this diagnosis. Of course we had a conversation, and I put him at ease by telling him that we can treat HIV today, but it would have huge health impacts on his life for the rest of his life and on many levels, not just health but social and economic. In B.C. we got universal access to PrEP just two weeks prior to this appointment with this patient. My heart sank, because I felt like he had just missed the bus.

I don't know if this committee has heard about PrEP. It's a treatment you can take every day that's more effective than condoms to prevent HIV acquisition. I just think that today in Canada we should not have any new HIV infections. I really think we should have universal access for people at risk of getting HIV. That's another point.

I have one minute, so I'll to go to my next patient. My next patient was a lovely guy. He's in his mid-eighties. I've known him since he's been in his sixties. He has HIV, well controlled, and some other health issues. You get health issues after 70, as I always tell my patients. But he's doing well and he's working every day. The last time I saw him I had a bit more time, so I asked him, “Why are you working every day? You're in your mid-eighties. It's not for financial reasons.” He told me, “ I wouldn't know what else to do. All my friends have died, and all my family have died, so this is what I can do.”

Why I bring up this point is that, for the LGBTQ community in the future, as they age, we're going to see more social isolation. We know that loneliness is a disease in itself. You can read up on the health impacts of loneliness. That's why I bring up this point. It's really a concern for us, because we know our patient population is aging. How are we going to deal with loneliness? You can ask me in the question and answer period if you think I have any suggestions.

● (1540)

That was my last story.

The Chair: Thank you very much. We definitely learn from the stories.

Now we will go to Ms. Fach.

Ms. Crystal Fach (Co-Founder, Diversity ED): I am also going to start a timer.

The Chair: I like it.

Ms. Crystal Fach: Good afternoon, and thank you for inviting me to speak to the committee.

I want to start by introducing myself. I am Crystal Fach. I am a 39-year-old queer, polyamorous women, single mother, who works as a professional advocate, educator and front-line support work and co-founder of Diversity ED.

I also smoke, have been impacted by violence, have a history of addiction, have lived in poverty and have had prior suicide attempts. In the LGBTQ community, I know that I have a lot of privilege. I am white, cisgender, able-bodied and straight passing.

Now I would like to tell you why I'm really here today. Early on in my career, I was working with an amazing transgender youth, 17 years old. He came to my LGBTQ youth drop-in. He had to lie to his parents as to why he was attending. His parents were very unsupportive of who he was. He would crack jokes, drop hints, and he knew it was not going to be okay to come out.

One day, he and I started practising coming out at home. The best way I prepare kids for coming out is to role play two different reactions, that of a loving response and that of an angry one. I always make sure my youth know what they are walking into and have a safety plan attached.

My young man's story did not go well. It became heated. He was assaulted and a few days later hospitalized for a suicide attempt.

While in hospital, I started to visit this young man. Nurses called him by his dead name and misgendered him. The psychiatrist did not give him a referral to any type of doctor who would even begin to talk about hormones, and the parents threatened his post-secondary education if he did not fall in line.

I wish I could say that this youth found support and then lived a happy and full life. He did not. He died by suicide within six months of leaving the hospital.

Many people had an opportunity to validate and support this young person, in particular the health care system, the nurses, doctors and psychiatrists. What I know is that if youth have people in their lives who validate and support them, they decrease their risk of suicide by 90%. That is a stat that I have sent forward.

Our health care system failed him, and unfortunately, I see and read of the system failing people every single day. I have spent most of my career working with and for LGBTQ youth and their families. I have also been a family support coordinator and program developer for Canada's first and only transgender drop-in centre, in Windsor.

I come here today not just to share some statistics with you, but to share the stories of the very people that the health care system in Canada has been harming.

Let's start with the system as a whole. We do a disservice to gender-diverse folks when we revolve everything we do around gender: dorms and hospitals, gendered treatment centres, inaccurate genders on health cards. Yes, I know that these can be changed, but their files with previous gender are also attached to the card and gender marker. Changing documents is also expensive and can be unsafe for certain people.

I have another story. A transwoman I have been supporting had kidney stones. We went to hospital together. She wanted an ally to be there just in case. All ID had been changed. She had what uneducated folks call that “passing privilege”, which is really harmful.

When at the desk checking in, she was asked if she was pregnant. The client then came out to the staff that she was transgender. The first thing said by the staff was, “I never would have known you were not a real woman.” This might sound like a compliment, but it's the very opposite. My client was once again told that she is not a real woman.

When asked where she would be placed in the hospital, they refused to answer, which put her in a state of anxiety. Now imagine you are a transgender woman and you don't know if you are going to be put with men or women. Finally they agreed to put her in a women's ward, and then said, “Don't think you're going to get your own room. It's not happening.” This woman never asked for accommodations, but under the law, she very well could have.

While there, the nurses and doctors were told that the client was trans, and she was misgendered by almost every nurse and doctor she came in contact with. The nurses were overheard at their station saying, “Look at it putting makeup on.” She was so uncomfortable and in so much pain—I don't know if anyone here has had kidney stones—that she was more worried about putting on makeup to make the nurses and doctors feel comfortable than sitting in her pain.

● (1545)

This person has experienced kidney stones since. Do you think she'll go back to the hospital? Not in the least. This is not a stand-alone situation. I have many stories of trans folks being discriminated against in hospital.

This person has made three suicide attempts since this incident, and has become housing insecure and is relapsing consistently, and she had almost a year of sobriety before this situation happened.

As for recommendations, hospitals should have a mandatory audit of their spaces, forms and procedures when it comes to services for gender-diverse folks. Some hospitals have already done these audits. The problem now lies with the government's reporting. It is not always necessary to ask for gender information, and when we do we need more options besides male, female and other. Other is not an option.

Transgender is also an umbrella term and will not pull accurate data. Also, if we're not collecting data to measure the needs of transpeople then the government will never have a realistic view of what the needs truly are. We also need data so the government can start investing money into the sectors that service transpeople and their families. We need to stop measuring LGBTQ people as one large group. Sexual orientation and gender identity have different oppressions and are treated very differently in society.

We need to start thinking about putting money into the most marginalized in our community. Funding needs to go to organizations that are trans-led and working on preventive and crisis work for transpeople and keeping them healthy and safe.

Mental health and addictions in our community are at a high level. LGBTQ people experience stigma and discrimination across their lifespans and are targets of sexual and physical assault, harassment and hate crimes. This increases their risk of experiencing mental heath concerns. LGBTQ people are not mentally ill due to their identity; they experience illness due to how they are treated in society.

One of the stats I'd like to share with you is that 77% of trans respondents in an Ontario-based survey had seriously considered suicide and 45% had attempted, and this was in a year. Let’s digest that number for a second: 45%. We have an epidemic in our community and it needs to be treated as such by our government. We no longer get to put our fingers in our ears and let one more gender and sexually diverse person die by suicide. We can change these things.

Trans youth and those who had experienced physical and sexual assault were found to be at the greatest risk. Some research suggests that use of alcohol, tobacco and other substances are two to four times higher in LGBTQ populations, and 37%—this number may have gone up—of homeless youth identify as LGBTQ. That's an alarming number, and we need to be putting more effort into looking at that as well.

We need to stop allowing physicians to ignore or diminish the existence of transgender people. Transpeople need access to hormone replacement therapy. They should not be told to prove they are trans or wait until they are a bit older. Putting off hormones for a transgender person could mean life or death. Gender dysphoria is a real thing that can lead to suicide and significant mental health concerns.

Youth should have access to hormones and hormone blockers when asking for support from physicians, regardless of their parents agreeing or disagreeing. This becomes a child protection issue and medical neglect in my opinion. Hormone blockers are safe and give children and youth breathing room to stop irreversible changes to their body through the puberty process. We need to start making sure that our youth are being medically supported. I don't know how many appointments I went to with youth, having to advocate for them to get the medical attention they need because physicians don't understand how to prescribe hormones or blockers. More education needs to be mandated because we're losing more and more kids, and this is not okay.

Some more recommendations would be more training mandated to the health care professionals, both in hospitals and throughout their early education. Better data collection would be another. We need to start getting stats for transpeople. We can't keep putting all LGBTQ people in one cluster because we're losing so many opportunities to learn more information. We need more LGBTQ visibility in preventive health care initiatives like smoking cessation, suicide prevention, mental health, addictions, and on government committees.

● (1550)

We need to remove unnecessary gender dorms or services. For example, treatment centres are gendered due to fraternizing. This is very heteronormative and excludes non-binary people. No government funding should support marginalizing already oppressed populations. Finally, government-run systems should never be participating in this marginalization themselves by creating physical barriers to access.

The Chair: Thanks very much. We'll have lots of chances to ask you questions and go into it further.

Now we'll go to the Kelowna Pride Society and Dustyn Baulkham for 10 minutes.

Mr. Dustyn Baulkham (General Manager, Kelowna Pride Society): Thank you, Chair and all the members, for allowing me the opportunity to speak today. I'm honoured and humbled by your request.

First, I do want to recognize that I live and work on the unceded territory of the Okanagan Syilx people.

I also want to share that I use he/him pronouns. I would also challenge the committee to include pronouns on your name tags so that we know how you identify when we're addressing people in the room, because obviously, we can make assumptions, but we're trying to say not to do that, right? We want to address people how they are as individuals. As well, when I speak today, I'll often use the term "LGBT", but with Kelowna Pride, as well as personally, we use LGBT2Q+ as our general acronym.

When I first received the request to serve as a witness, my main question was, why me? I was looking at a lot of doctors and people who work with different LGBT health organizations, so I wasn't quite certain how I was selected or why. I've been thinking about it in the last couple of weeks as I was going through that process of "What am I going to say?" I obviously want to make sure it's valuable to the committee and the people who are taking part in the standing committee, so I'm going to offer my experience. I don't have the research or stats that go along with it, but it's going to be a bit different as a perspective for this committee.

I'll provide some of my context and background. Over the last 10 years, I've served on various boards: the Vancouver Pride Society, Fierté Canada Pride, which is a national association for pride organizations, and the Kelowna Pride Society as well. During what I call my previous life, I was a banker and I also served on LGBT committees in the bank.

I grew up in small-town Saskatchewan, in Maple Creek, with a population of under 3,000, but I've also lived in Kelowna, Chilliwack and Vancouver, as well as a little closer, in London, Ontario. Just after my term as president of the Kelowna Pride Society, we managed to find a grant which let me be hired as the current general manager. It's a part-time paid position. I'm also the executive director of the Arts Council of the Central Okanagan. As well, I have my own events company that specializes in LGBT events, but not exclusively.

Most of my examples and stories will focus on Kelowna, but that takes into account experiences I've had around the country and in my various roles.

To start off, Kelowna does not have any kind of dedicated LGBT space, which is why we do various events throughout the months of the year to try to provide that safe space for people, but at one time we used to. The Kelowna Pride Society, which was originally incorporated as the Okanagan Rainbow Coalition on June 15, 2004, started the space. That happened when I was at the University of British Columbia's Okanagan campus. Later that year, they started a community centre that was the safe space for people to meet and congregate. They had regular drop-in hours, and various different groups met in that space. The way they paid for the rent on the space was by getting a special occasion liquor licence every Saturday night. They served and sold liquor. That was actually how we paid for it.

This was obviously a time much before apps such as Grindr and whatnot were out there to connect people. It was just a space where you could be yourself, and people from the various elements of the LGBT community were always there. In the seven years that I've lived in Kelowna, in two different spurts, it was one of the few times that we actually saw many people from the trans community come out to events. Unfortunately, it closed around 2013 because of liquor law changes. We could no longer afford to run that space. The challenge of being a pride society is that we don't qualify for charity status, so we can't get certain grants that are out there. While we've found some workarounds in certain ways, it still does provide a bit of a challenge.

On a positive note, the one thing that has come up since it has closed has been the Etcetera Youth Group. Every Thursday—so actually later today—they get to meet. They call themselves the Glitter Critters. It's a free drop-in group and they have two different age ranges: 11 to 14 and 14 to 18. Lately they've just been bursting at the seams because of the youth who come there. Originally, it was created by Kelowna Pride, but again, to go back to that charity status, we couldn't get the appropriate grants to do it, so we partnered with other groups to ensure this program was sustained.

I won't go into detail about some of the challenges that happened about a year and a half ago, but it did almost shut its doors. Thanks to the community coming together, Bridge Youth & Family Services now is the primary organization that actually runs the Etcetera Youth Group, and it's run out of the Foundry, which is part of the Canadian Mental Health Association in Kelowna. As well, the Boys and Girls Club is part of it, as is the Kelowna Pride Society, and then there are a lot of engaged community members. Partnerships like these in smaller communities are the way that we've found to actually make sure that groups like this can exist, both financially as well as from a space.

● (1555)

After I was asked to speak to this committee, I reached out to one of the facilitators, because while I've supported the program both personally and from my company, I wanted to learn a bit more about what people are seeing on the front line, people who don't have the opportunity to come here to speak today as I did.

Leslie is one the facilitators. She used to be on the pride board. According to her, the program seems to cater more to the trans/non-binary kids, as they are the ones needing the most support, but of course, all are welcome to attend. What she has seen is that the majority of the trans/non-binary creators who come to Etcetera are on the autism spectrum. She feels this might be because the trans kids who are not autistic are capable of creating and maintaining strong support networks without a group. She admits that she has seen a skewed sample of kids, as she only sees those who attend. I want to add that Leslie has her master's in social work and is a clinical counsellor, so it's not just some random assessment by an uneducated person.

In the group, she estimates that approximately 5% to 10% of the youth in attendance are not out to their parents; they're lying to their parents to go to this group. She has also shared that some of the parents of the youth who attend have refused to use their actual pronouns. On the flip side, the youth attending some of the Etcetera drop-ins have been able to work with some of the parents to help educate them, and they have come around and started to accept these youth for who they actually are.

In the past in Kelowna, we've had different groups such as a gender identity group and Senior Gay Men in Kelowna, but these groups have fallen apart in the past year or so due to lack of leadership, human capacity and financial resources. At the time, these groups were well regarded, but the people leading the groups have their own struggles in life and didn't have anywhere to turn, so they had to step down to focus on themselves. We need people with lived experience running these groups. It can't be someone like me, a middle-aged, cisgender white male. I can't step up to run the gender identity group, because I don't have that lived experience. I think Crystal addressed this previously.

All the smaller communities I've lived in lack safe spaces for the LGBT community, and I honestly think the apps that are out today have made that worse. Back in the day, people would often turn to gay bars and gay centres, but with people not attending these places as much because they feel they can get what they need from an app, they don't have those resources anymore. From what I've seen in my various roles at pride and the events that I run, people are more lonely now than they have ever been, because they don't have those shared spaces and hubs, and that's what I think we need more of, especially in smaller communities.

One thing I've seen through my years with pride societies—and I do this myself sometimes—is this internalized view of homophobia and transphobia. What I mean when I say that is, based on past experiences, if someone or some group, business or organization does not blatantly say or show that they are welcoming to the LGBT community, we assume they are not welcoming at all. This is why we have created some of the events we have in Kelowna for the LGBT community and bring people into businesses. It's the same when it comes to health care and doctors. Just looking at someone, you don't know how they identify or whether they have knowledge of the LGBT community. This can be a barrier to getting medical help when you're scared to go in. I've experienced this myself many times.

We need resources and hubs of information where we can find the inclusive and welcoming doctors who will understand our unique needs, whether I'm a cisgender white gay male or a transperson. It's difficult enough to find a family doctor, let alone to find one who understands the LGBT community.

I know in B.C. that Trans Care BC has been doing a great job of bringing together those resources for the trans community. I saw they're coming to speak next week, which is great. I know they support TransParent Okanagan, which is a local group started by parents who had trans children and wanted to support other parents going through that same process of trying to understand their trans youth. Trans Care's work, especially in the interior, has reduced the number of requests Kelowna Pride has received for trans-inclusive doctors. We used to get those on an almost weekly basis, and we had nowhere to turn to provide this information, outside of a friend of a friend recommending this or that doctor.

In closing, I am looking forward to seeing what comes from this committee and how the health of the LGBT community could be better supported.

Thank you for allowing me the time to speak today.

● (1600)

The Chair: Thanks very much.

Now we have Ms. Fearman. Thank you for patiently waiting. You have 10 minutes.

Ms. Loretta Fearman (Chapter Facilitator, Barrie-Simcoe County, Pflag Canada): Thank you for this opportunity.

My name is Loretta Fearman—pronouns she/her. I am the proud parent of a gay son and a lesbian daughter. I co-facilitate Pflag Barrie-Simcoe County, which we started three years ago after attending parenting LGBTQ2I youth workshops in Midland, Orillia and Barrie. We recognized the need for peer-to-peer support for those who are raising LGBTQ2I youth, more specifically, families raising transgender youth.

I present today a snapshot of the lives of three of our families—the names have been changed—and I offer recommendations necessary for our youth to survive and thrive.

Here is our first family. Sarah is an intersex youth, assigned male at birth, living in Barrie—pronouns she/her. Sarah's mother writes that for years they knew that something was different about their child. When she started puberty, they knew something wasn't right. They asked the family doctor about the lack of genital growth. She said it was nothing to be concerned about. A few years later, Sarah started questioning her sexual orientation, and soon thereafter her gender identity. The doctor referred them to the Transgender Youth Clinic at the Hospital for Sick Children. Sarah was no longer identifying with her gender assigned at birth.

After several appointments and blood work, the results showed that her hormone levels were off, and she was diagnosed with partial androgen insensitivity syndrome, a type of intersex condition. If doctors were more aware of the spectrum of intersex conditions, Sarah could have benefited by going on hormone blockers at a younger age.

There is much stigma about being intersex. They are not accepted by cisgender folks, and they are not accepted by the trans community. That is why many intersex people, like Sarah, choose to identify solely as trans. Intersex folks need validation and acceptance. Life has been stressful for Sarah. She experiences shame, guilt and anxiety, and her depression has made it difficult for her to go to school. She has started self-harming and has been on suicide watch several times. Her mother still cannot go to bed until Sarah has fallen asleep. Sometimes it's not until 3:00 or 4:00 in the morning.

Next we have Joe. Joe is a cisgender gay youth living in the Blue Mountains area. Joe struggled with coming out. He finally came out to his mother, Nancy, at age 14 and immediately asked for conversion therapy because he did not want to be gay. Joe was taken to a therapist prior to seeking out conversion therapy. The therapist told him that conversion therapy does not work and has caused extreme harm to individuals. He insisted that only his mom know that he is gay. The unawareness has put an excessive amount of stress on his family.

Joe's grades have declined, and he regularly skips school. Now, at age 15, he has started using drugs to self-medicate and has moved out of the house. His parents worry every day for his safety.

Nancy has reached out to various agencies for help. She started with New Path, an organization that works on a first-come, first-served basis. After a long wait and much paperwork, they referred her to the Canadian Mental Health Association, only for her to be told that Joe must be the one to request help.

The Georgian Bay Family Health Team helped when Joe was suicidal. However, when it came to long-term counselling, the family was referred to the CMHA in Barrie, 50 minutes from where they live. Not having a local agency proves difficult for Joe and his family. Nancy tells me that her family is in crisis and that they do not know where to turn, so she continues to make calls.

Joe is one of our fortunate youth because his family loves and accepts him. There are many LGBTQ2I youth who have been kicked out of the house by unaccepting parents.

We know that approximately 40% of the homeless youth identify as LGBTQ2I. We know that we live in a heteronormative society, and we know that for many LGBTQ2I folks, stigma still exists, contributing to their shame, self-denial, internalized homophobia-transphobia, self-harming, anxiety, depression and suicide.

● (1605)

Education in Canadian schools is essential to normalize gender diversity and provide an understanding of diverse sexual orientations. When youth talk about their experiences and identity freely without shame and fear, it makes them feel normal.

Here is our third family. Tom, 16 years old, is a transgender boy—pronouns he and him—living in Simcoe County. Tom's mother has shared their story. Tom did not identify with his assigned-at-birth gender, but due to a lack of education and resources, it wasn't until grade 9, at age 14, that he realized what it meant to be transgender. After extensive research, they asked their family doctor for a referral to a local medical doctor who specializes in transgender patients. Several months later, they got an appointment. On April 21, 2017, Tom began taking testosterone.

When they sought a referral for top surgery, they decided to go to Montreal, since Toronto wait times were one year longer. The medical documentation required for surgery approval was arduous. It resulted in multiple visits to several professionals simply for the purpose of filling out paperwork. The wait for approval was significant. Once approved, only then could Tom go on the wait-list at the Montreal clinic. OHIP's predetermination for surgery is valid for only two years. Fortunately, it did not expire, but during this wait time, Tom became increasingly depressed. He had to be hospitalized and was put on suicide watch.

Tom had top surgery in July 2018 in Montreal. This required time off work. All expenses were paid out of pocket. The surgery was successful. Tom became a different person. Today Tom is a confident boy who no longer needs mental health counselling in Whitby for body dysphoria. He no longer takes prescription medications for his depression. Tom doesn't need to waste a half hour every morning taping and every evening removing the binding tape from his raw skin.

Tom has since switched to a local doctor who specializes in pediatric endocrinology. In February 2019, they submitted the paperwork to OHIP for approval of Tom's next surgery, a total hysterectomy, this time in Toronto. They recently received the approval from OHIP, but again, it's valid for two years. They now wait for his surgery date. Tom's wait times so far have been far less than other transgender folks in similar situations. However, any delays for support and medical care that could detain him from feeling his authentic self have been extremely difficult on their family, but primarily on him. They say they can only imagine what families who have different economic circumstances and longer wait times must face when it comes to the safety and mental health of their loved ones who are seeking surgery.

We have a number of recommendations.

We need medical and support staff to be cognizant of using correct pronouns, preferred names and current terminology.

We need gender and sexual diversity included as part of health education taught in Canadian public schools and in post-secondary medical training. We would like hospitals to form committees that include LGBTQ2I folk, much like Orillia Soldiers' Memorial Hospital has adopted.

We would like to ask that there be adequate funding to support ongoing programs in such LGBTQI organizations as Rainbow Health, Egale, AIDS committees, and regional organizations like the Gilbert Centre. They are essential for the community to survive and thrive.

We need hospitals in every province where gender confirmation surgery is accessible and affordable so that dangerously long wait times are reduced. We need mental health care for ages two to 24. Currently, there is a gap for children under the age of 14, and more support is needed for our youth who are 14 and older.

● (1610)

Finally, we would like to see ongoing media campaigns resembling the new LBGTQ2 commemorative loonie—"50 years of progress"—where facts are shared in a positive manner to educate the public.

Thank you.

The Chair: Thank you very much.

We'll now go to our seven-minute round of questions.

We're going to start it off today with Dr. Eyolfson.

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

Thank you to all of you for coming. This has been a very interesting study. We've learned a lot of very important things.

Ms. Fach, as a physician, I am ashamed to hear the stories you are telling of your friend's experience in the medical system. I graduated from medical school 25 years ago. I know there were attitudes like that then. I was hoping that in a quarter century things would have changed, but they apparently haven't.

We talked about support for young people. The subject has come up of gay-straight alliances in schools and how valuable they seem to be. We hear universal praise for these associations and how they need to be protected. We also know that there are some school officials and politicians who are insisting that the parents of children who attend these have to be notified.

What would you say to those who advocate for such a policy?

Ms. Crystal Fach: That is going to be a safety concern because not all youth have parents who are accepting. If you're needing permission slips for kids to attend these programs, we're going to lose more kids again. We're going to create more isolation, or we're going to cause harm at home. That is 100% a safety issue. We cannot out kids ever. That needs to be kiboshed for safety reasons for sure.

Mr. Doug Eyolfson: Thank you.

Mr. Baulkham, would you agree? Do you have anything else to add to that?

Mr. Dustyn Baulkham: I agree 100% with what she's saying.

Mr. Doug Eyolfson: Okay. That appears to be the feeling of everyone we have spoken to, yet we still hear this.

Dr. Wasserfall, you talked about elderly LGBT people and some of the isolation they have.

We've heard from some that there's a problem when they reach the point where they can no longer live independently and are in care. They've described some of the experiences that some of these people have had in care homes. There's a phenomenon, apparently, of elderly LGBT people becoming re-closeted, as it were, because of the environment in personal care homes.

We need to fix this. Do you have any idea of what kind of solutions we might have or how we can start addressing this?

● (1615)

Dr. Tinus Wasserfall: I don't have the solution, but yes, unfortunately I've had those experiences as well with patients who get very frail and go into care homes. They really get treated poorly as far as their sexual orientation goes.

The question is the same for the general population. We need to keep our elderly patients healthy and living independently for as long as they can. I think that a part of that for the LGBTQ community is creating social networks, and that's possible.

Some of that is happening in Vancouver, where we're engaging elderly people in their own social networks to be more socially apt. We know that social interaction keeps people healthier, and that goes with being more physically active. We've seen some of those programs in Vancouver, specifically for gay men, and they've been very successful. That's one of the suggestions I would make.

What I've heard again and again today, which is interesting because all of us talked about that, is that education of any person who works in the health care system is super important. I was thinking about it. Whether you're the receptionist welcoming a patient, the person who takes blood from a patient, the doctor, or the care aide at the elderly care facility, whoever you are in the health care system, it's super important. There needs to be a systemic approach to anybody who interacts with people and patients.

Mr. Doug Eyolfson: I would agree.

As I've said to a number of panels, 25 years ago the sum total of our medical education on this issue was that it's probably a good idea to be nice to gay people. That was pretty much it. Again, it doesn't sound like things have really improved over time.

Dr. Tinus Wasserfall: As I said when I spoke, at this moment it's either a non-existent or an opt-in educational experience for health care professionals. I'm talking about doctors.

Mr. Doug Eyolfson: This is changing gears a bit. This is purely a medical question.

You talked about your recommending screening for anal cancer in gay men, this being similar to the demographics for cervical cancer in women, and we know HPV infection can be a precursor to that.

Would you recommend HPV immunization for that population?

Dr. Tinus Wasserfall: For sure. Once again, I can only talk about B.C., but in B.C., HPV immunization is now approved by the province for people up to the age of 24 years. I think that's a little bit too short of a time span. I don't want to get too much into the science of it but to give you an idea, in the general population, anal cancer rates are 1.5 incidence rates per year, 1.5 to 2 per 100,000. It's fairly low. Cervical cancer rates pre-screening, before there was the cervical pap test, were 35 per 100,000. In the gay men population, it's estimated that anal cancer rates are about 45 per 100,000. It really begs to be screened and to have effective treatments.

There have been studies that have shown that even in what we call post-exposure, ideally the HPV vaccine needs to be given before exposure. That's why we give it to nine-year-old kids. That's when it's most effective, but there have been quite a few studies both in men and women in post-exposed people who have evidence of HPV-related disease that the vaccine is still effective. It's to a lesser degree, but it's still effective.

Just as a reminder to this committee, HPV is like the common cold. Everybody gets it. I think that a vaccination is very important for the whole general population, but definitely for the gay men population.

Mr. Doug Eyolfson: Thank you very much.

The Chair: The time is up.

Mr. Lobb, you have seven minutes.

Mr. Ben Lobb (Huron—Bruce, CPC): Thanks, Mr. Casey. It's nice to see you today.

The first question I have is for our good doctor here.

Is there any legal reason why a doctor would address somebody as "mister" who was born male, is trans to female and who identifies as female?

It seems that every single time we have a guest come in on this topic, one of the first complaints is always that doctors are not referring to them the right way. I am wondering if there is a legal reason they have to call someone “mister”.

● (1620)

Dr. Tinus Wasserfall: There is no legal reason at all, no. I think it's more a failure on the health care professionals' side to address people in the correct way.

As I stated at the beginning, I've been working with this community for a long time, and we are still doing training on the right terms and the right things to say, because we want to treat our patients first of all with respect.

Mr. Ben Lobb: What do I know? In a case where someone born a female identifies as a male today, would they, from a doctor's perspective...? I'm thinking of a mammogram. What do you do for something like that?

I'm just curious. I don't know how they would even begin to know or what.

Dr. Tinus Wasserfall: It goes the other way around as well.

The patient I talked about was male born who transitioned to female. With prostate exams or prostate biopsies, it's the same thing. I don't know about the rest of the country, but in B.C. it doesn't really matter. There are some billing codes that are male or female related, but it doesn't matter for all the rest.

Mr. Ben Lobb: What about a driver's licence in British Columbia?

Dr. Tinus Wasserfall: For the driver's licence in B.C., you can now opt out.

Mr. Dustyn Baulkham: You can choose X.

Dr. Tinus Wasserfall: You can choose X. I think that legally the terms are becoming—from my point of view, I'm just a doctor—less important. It's more about the way that person acts.

Mr. Ben Lobb: Maybe some of my colleagues already know this stuff; I have no idea. You're a doctor and that's why I'm asking you.

If somebody who has been in a major car crash comes into emergency, what are they to do at that point in time?

Dr. Tinus Wasserfall: They can speak for themselves.

Mr. Ben Lobb: I'm just wondering how you would know how to address somebody. I know you wouldn't want to offend anybody, if possible. Dr. Eyolfson was an emergency room doctor. He wouldn't want to offend anybody. Maybe he can answer that. How would you do it?

I have no idea. I'm just trying to think of a sensitive way for these people to be able to do that.

Dr. Tinus Wasserfall: If they can't speak for themselves and they don't have family members or next of kin who can speak for them, the common thing to do, in medicine in any case, if you do make a mistake and you realize you have made a mistake, is to disclose that mistake as soon as you can, to rectify it. In that situation I don't think it's life-threatening or whatever. I don't think it's the end of the world.

Mr. Ben Lobb: What's considered reasonable?

Dr. Tinus Wasserfall: It's more reasonable that, once the patient is able to speak and say, for example, that they are a female and they've been addressed as a male or their records are under male, we say that we are so sorry, that these were the reasons and that we'll rectify it. That's how medicine works.

Ms. Crystal Fach: Can I make a comment?

Mr. Ben Lobb: Sure.

Ms. Crystal Fach: Even if their records or their ID doesn't say they are female and they're female and they're telling you that they are, you still need to call them a female. That's important as well.

● (1625)

Mr. Ben Lobb: Yes, okay.

I wanted to ask another question. I can't remember who brought it up. Maybe I have this incorrect, but it was about GPs prescribing hormones for transpeople. Are our guests here today asking that all GPs in Canada be knowledgeable about that, or are they saying if a transperson—maybe I'm using the wrong term—or if somebody comes to a GP and says that they're interested in hormones, if the GP doesn't have a clue what to do, they refer them to so-and-so specialist? What are we saying here today?

Dr. Tinus Wasserfall: In B.C., we have a specific assessment schedule or requirements that need to be gone through. We have specially trained physicians.

The question you have asked really becomes difficult with adolescents or pre-teens because we know there is actually harm to be done with pre-teens who are really gender dysphoric, do not get hormone therapy and then go through puberty in the sex that they do not feel comfortable with. In B.C., we definitely have specialty doctors who do the initial assessments and then give their recommendations. It's quite an extensive assessment. It's not just saying, “I want this or I want that”.

Mr. Ben Lobb: If a doctor was in rural and remote B.C. and someone came to them, would they have any clue what to do or who to refer to? Is there a thing through the B.C. health association or something that would say this? What is it?

Dr. Tinus Wasserfall: There are quite extensive online resources for doctors specifically around this topic. With adults it's easier, but with pre-teens and teens we prefer that they be assessed by a specialist. The specialist can make recommendations and we, as GPs, prescribe onwards.

Ms. Crystal Fach: I've specifically experienced with youth that a lot of times they are not heard, or they are told they are bipolar, or it is just a phase or a contagion. Then those next steps aren't happening. It's the same thing with adults who are trans. A few of my adult trans folks have been diagnosed with bipolar disorder or had doctors saying they are not comfortable prescribing hormones, but they already prescribe hormones to cisgender women all the time. It's nice if they can be sent to an endocrinologist, but that just adds a wait period, which puts them at risk again for suicide.

We just need to make sure that people's voices are heard and validated and not continuously questioned and doubted.

The Chair: The time is up.

Mr. Davies, you have seven minutes.

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

Thank you to all the witnesses.

Dr. Wasserfall, what is the youngest age that a Canadian child can be in order to start receiving hormone therapy or gender assignment surgery? Is there a minimum or maximum age?

Dr. Tinus Wasserfall: There isn't an age. The question around that is more about age of consent. We've had that discussion in our group.

Puberty does not start at a specific age for every person. There is a range, so I don't think there is a set age, but definitely, the specialist —I am not a specialist in this field—who treats these kids really wants to try to treat them way before they start puberty.

I'm just going to guess, probably 10 years in boys, and maybe younger in girls.

Mr. Don Davies: The committee did a bit of cross-Canada travel on this. We went to Montreal, Winnipeg, Calgary and Vancouver.

I'll direct this question to Ms. Fearman. I think that in Alberta you require the authorization of two psychiatrists, who must sign off before gender assignment surgery is permitted.

Is that the case, and if it is the case, is that warranted?

Ms. Loretta Fearman: In Ontario—because I live in Ontario—for genital surgery, yes, they need two physicians. If it's for breast removal, then they need only one physician, but they also have to be on hormones and they have to see some kind of psychologist who will give approval and say that yes, the person is experiencing dysphoria, and then put them on hormones.

However, for young children who have not started to go through puberty yet, they can go on hormone blockers, which gives them some time. It gives them time to really know who they are. It just puts their puberty on hold. That's the safest way to go for young children.

● (1630)

Mr. Don Davies: I don't know if anybody knows the answer to this, but it would seem to me that a child of 10, 11 or 12 who is expressing a clear gender identity would feel relatively certain.

What percentage of those children, after going through puberty and maturing, end up changing their mind? What I'm trying to find out is, how reliable is that expression of gender at that age? Should we really be relying on it?

Ms. Loretta Fearman: I don't know any who have changed their mind. That's why I think putting children on blockers is probably the safest thing to do, because if they do change their mind, then as soon as they go off the blockers, they'll just go into puberty as they normally would have.

Mr. Don Davies: Okay.

It would strike me that it would be unlikely that there would be a change of mind. It sounds like it would be a fairly clear expression.

Ms. Fach, in a brief to the committee the Quebec Lesbian Network said that sexually diverse women tend to be made invisible, both outside and within the LGBTQ2+ community, and that double discrimination, based on gender and sexual orientation, creates a number of issues related to the physical and psychological health of these women.

Do you have any evidence to give? Is that the reality of women from sexual and gender minorities? Is the reality that they are little known or invisible inside those communities? What can you tell us about that?

Ms. Crystal Fach: Well, I think that's with all women. We're sexualized in our community. We're not taken seriously by the main population. Often, our population is fetishized on TV, so that's what people see.

I know when I am out with my partner I am approached all the time by people in a bar or in a restaurant. They say very sexually inappropriate things to us because we are women and because we are queer women.

I think that a lot of times the focus, historically—and not that it should be, but it has—has been on gay men's health and there hasn't been a lot of talk about queer women's health.

Our movement has moved in a very precarious way. Our movement started with transwomen of colour and then the gay rights movement happened, and now we're back 20 years with the trans population again. Women's rights go along with our community, like feminism. It is embedded through every oppressed population.

Mr. Don Davies: Perhaps I could just drill particularly into lesbians' experiences, from your knowledge, with the health care system. We've heard that gay men often do not come out to their own physicians, and this presents a real barrier in terms of their accessing proper health care.

What do you know about the prevalence of lesbians feeling comfortable to come out to their doctors with their sexual orientation?

Ms. Crystal Fach: Sometimes it's not even necessarily about comfort, but I think we have opportunities to be outed more with the questions we're asked. For example, every time I go to the doctor, they'll say things like, “Are you sexually active? Might you be pregnant?” I'd say, “No.” “Well, are you using protection?” “No.” “Are you on the pill?” “No.” “Well, then how do you know you're not pregnant?” “Well, I'm gay.” I have to out myself on a regular basis to get health care.

I don't know. In my experience, I'm forced to be out more than I necessarily want to.

Mr. Don Davies: Doctor, we heard Dr. Eyolfson about the state of education when he went to medical school, and I'm disappointed to hear it doesn't sound like much has changed. I presume that you went to medical school more recently than Dr. Eyolfson did.

Dr. Tinus Wasserfall: Thank you.

Voices: Oh, oh!

Mr. Don Davies: That was an underhanded shot at Dr. Eyolfson, actually. No, I'm teasing.

Mr. Doug Eyolfson: I can never tell.

Mr. Don Davies: I want to ask about HPV vaccination. We know that HPV is also present in 90% of anal cancers.

What recommendations do you have, if any, regarding HPV vaccinations, particularly for boys and men aged 9 to 27 and for men over 27 who have an ongoing risk of exposure to HPV?

Dr. Tinus Wasserfall: That's a great question, one of my favourite topics to talk about. I'm giving a talk on it Monday.

HPV infection in men is different from HPV infection in women. It's not the same thing. Men tend to get less disease from HPV; women tend more to get disease. I'm not talking about the gay population; I'm just talking in general. Women tend more to get disease from it, but women clear the virus better. Men do not clear the virus very well, so the virus keeps hanging around. There have been great studies on this. Men up to their fifties and sixties have persistent staph oropharyngeal HPV infections that they don't clear. Men don't form good antibodies naturally to HPV infection.

Coming back to your question about the vaccine, what is the recommendation? Well, definitely boys should get it, because it's probably the only vaccine that prevents cancer. The vaccine is really about cancer prevention. The argument for young boys and girls is that it's not a sexualized vaccine; it's a cancer-preventing vaccine that everybody should get. In the MSM population, we highly recommend it because of what I told you about anal cancer rates. Those are important things, even though it's post-exposure, as I said. In the general population it's a question mark.

● (1635)

The Chair: Time's up. Thanks very much.

Now we go to Mr. Ayoub.

[*Translation*]

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

I would like a little more information on this quest for identity. When we were talking about young people at the beginning, my colleague Mr. Davies touched on the subject that really interested me, but I want to go a little deeper into it.

The search for identity takes place over time from childhood, through adolescence, and even into adulthood. When growth is slowed down by drugs that act on hormones, a possibility you raised, the search for identity can take longer and this is where it is most important to support young people on their journey. We were talking about the age at which these people are able to make decisions that will affect the beginning—or even the rest—of their lives. How do you see this support in terms of parents and society?

Dr. Wasserfall, you work in the medical field. Maybe you don't have young people in your clientele, but mainly adults?

I think this support involves several participants, several groups of people to support these young people and ultimately help them make the best possible decisions.

This is the subject I would like to explore a little further, Ms. Fach. You have told us a lot about what you have experienced and all the services you offer. Can you give me more guidance, give me a little more information about this?

[*English*]

Ms. Crystal Fach: I think you're absolutely right. Trans youth especially need that wraparound support. There already are some great physicians out there who are working with trans kids and their families. I think the family support, if they're willing to accept it, is the key as well. We know that these youth and children need their families around them, so providing those groups or the education for parents—

Mr. Ramez Ayoub: I'm sorry to interrupt, but you said “if”. The problem is when there is no acceptance of the problem, and they don't recognize the problem—

Ms. Crystal Fach: Yes.

Mr. Ramez Ayoub: —if it is a problem. It is a problem for those parents who don't recognize it.

What should we do? What do we do with those kinds of...?

Ms. Crystal Fach: I think it's starting to change. With local child protection agencies I've worked with it becomes an issue of neglect at some point. It becomes harmful to allow your child to suffer with dysphoria. I think that child protection at that point needs to step in and provide that supportive environment for those young people. Maybe that will be the aha moment for those parents to say what's going to happen is they're going to lose their children. I've seen them lose their children to suicide.

At any cost, we need to make sure that these kids are supported first, and then how we can support their families.

Mr. Ramez Ayoub: The support should be from school, from kindergarten, or....

Ms. Crystal Fach: It should be from trans-led organizations.

I know there are a lot of pride organizations, and they do great work—don't get me wrong—but they're often led by cisgender people. They have the token transperson who does the group once a month. There are trans-led organizations doing that work, and we need to better support the trans educated people in our community to start leading these groups and having their families support the families that are becoming attached to these kids. That's where money needs to be funnelled.

These trans-led clinics are needed. The trans kids clinics do great work, because they do that holistic wraparound approach as well.

● (1640)

Dr. Tinus Wasserfall: I don't know if you agree with me, but it's my personal opinion that in sexuality there is more fluidity than in gender identity, although there could be some fluidity, but I agree with what the previous speaker said.

None of my trans patients have ever come back and said it's been a big mistake and they want to.... It's a very—

Mr. Ramez Ayoub: Is there any science report, or any research report that could show that?

Dr. Tinus Wasserfall: I'm not aware, but I've never come across that.

Ms. Crystal Fach: I think that some of the problems I've talked about are that we don't do a lot of data collection on specifically transpeople. We tend to group our whole community in one. I know Rainbow Health Ontario has done some, but it's such a small sample, and that's what I'm talking about. More data collection needs to be done on trans populations, because we don't have a lot of information out there.

Mr. Ramez Ayoub: I have another question.

[*Translation*]

If people in the gay community—men or women—stay in the closet as long as possible to achieve economic autonomy, to get a job or to get an education, does that economic autonomy, acquired through that work or education, allow them to have better health? Have you noticed if, for example, openly gay people who have a job and a stable economic situation are healthier?

[*English*]

Dr. Tinus Wasserfall: I think it's a double-edged sword.

Yes. A lot of gay people defer coming out because they want to have education and they want to advance their lives and not be in fear of being—

Mr. Ramez Ayoub: Rejected.

Dr. Tinus Wasserfall: —rejected by family or cut off financially.

I think the longer people are not themselves can also lead to more mental health issues in the long run. The longer you are not who you're supposed to be and the longer you suppress yourself, the more other psychological issues come up. That's why we see a lot of mental health disease and, unfortunately, addiction. I'm talking about the gay men. I think that's part of it. You cannot force anybody to come out about their sexuality, but they defer it and that leads to other issues long term.

Mr. Ramez Ayoub: Do you see a difference in your practice between those people who are economically well off and those who are not?

Dr. Tinus Wasserfall: Yes, but that also goes for the general population. Generally, the better you do financially and the better educated you are, the better your health outcomes. Yes, for sure, in the gay men's population that is true. They have better health outcomes with better education and economic status.

I don't know if deferring coming out is helping that. I think it can go either way.

The Chair: That finishes our seven-minute round. We'll go to a five-minute round

Mr. Richards.

Mr. Blake Richards (Banff—Airdrie, CPC): Thank you.

I'm actually not a regular member of this committee, just for the benefit of our guests. This is my first opportunity to be part of this study. I'm not sure how many meetings there have been prior to this one. I wanted to put that out as context, because if some of my questions are very basic, that is why. I don't have the background on this study that some of the other members on the committee would, but I certainly do appreciate your being here and sharing your experiences and knowledge with us.

I guess I will ask some basic questions. I won't direct them at any one individual. All of you can answer them or any of you who would like to answer them can do so as well.

I will start by taking a look back and then a look ahead. That's where the questions will come from.

It's been really clear to me, listening to the experiences that you've had or that you shared of others that you're aware of, there's a long way to go in terms of how we allow people to be themselves in our society.

We've certainly come a long way, as well. I think back to where we were 20 or 30 years ago and where we are now. At that time, if you think about athletes, entertainers or actors and people like that, they would shy completely away from, as we would say back then, coming out of the closet. That certainly is something that I don't think we see anywhere near to the same degree now, and there are all kinds of other examples we can give of that.

From that point, would any of you disagree with me that we've come a long way over the last 20 or 30 years? I understand we have a long way to go, but would any of you disagree that we've come a long way?

● (1645)

Dr. Tinus Wasserfall: As I stated at the start, I'm a gay married man, so yes, we've come a long way.

Mr. Blake Richards: I just want to make sure that nobody disagreed, because I want to give you the opportunity to disagree and tell us why.

Ms. Crystal Fach: I think the lesbian, gay, bisexual—the sexual orientation—part of our community has come a long way, but the trans movement has really just been starting over the last few years.

Mr. Blake Richards: That's fair.

I want to take a look at the progress that has been made and get your take on it. Anyone can answer. Has that been because as more people have come out to be themselves, society has become more accepting, because society has changed its views on things?

We all had that experience of knowing more people who have come out or however you want to put it. Again, I apologize if my terminology is incorrect. I don't have the background on this study. Is that something government has done? Has government produced that change or progress, or is it some combination of the two? Does anyone want to give an opinion on that?

Mr. Baulkham, you look like you wanted to start. Whoever would like to, please go ahead.

The Chair: Ms. Fearman.

Ms. Loretta Fearman: First of all, I would like to state that 40% of homeless youth still identify themselves as LGBTQ2I, so I don't know that society has come as far as we would like it to. I am a very open and accepting person and have been my whole life. It took my children, aged 15 and 17, some time before they came out. There's still a lot of fear and stigma. I still see a lot of unacceptance, especially for the trans community. I still hear parents and people saying that it's a phase. I think there's a long way we have to go, and —

Mr. Blake Richards: Do you mind if I interrupt? My apologies, but there's just a limited amount of time. I do want to get to how we have a long way to go and what that looks like. I want to get to that, but I'm trying at this point to establish that there has been some progress.

Everyone seems to acknowledge that there has been some progress. I would certainly say we've seen that. I'm trying to get a sense as to what you think drove that progress. Was it something government did or was it a change in the attitudes of society that generated the actions of organizations that are advocating on behalf of those impacted? Whatever it is, I'm just trying to get a sense of that first. I'm trying to look back.

I want to give you this opportunity, but I want to start there. Do you have any comments on that right now? I can come back to this later if you'd like. Would you like to make some comments on that looking back piece? Anyone else can comment as well.

Ms. Loretta Fearman: I think government changes have been good and have been part of it, for sure.

Mr. Blake Richards: Is there anything specific you wanted to point to on that?

Ms. Loretta Fearman: I'd point to human rights, as far as same-sex marriage is concerned. I think that was huge.

Mr. Blake Richards: Okay.

Is there anyone else?

Mr. Dustyn Baulkham: I was going to say that it starts with the trailblazers and fighters who are down on the street. The government will ratify it and make that the legal side of things, but it's the people on the street who are changing people's minds and fighting for what we need. That's really where it all starts.

Mr. Blake Richards: I think that's a good way to—

Mr. Dustyn Baulkham: Sometimes the government is a little bit behind in some of that.

The Chair: The time is up.

Now we'll go to Mr. Ouellette.

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

[*Translation*]

I'd like to thank the witnesses for being here today. I'm very grateful.

● (1650)

[*English*]

The committee heard from witnesses who pointed out that access to health care for LGBTQ2 people can be difficult due to a variety of factors, including living outside major urban centres. Dr. Mark Gilbert told the committee that sexual and gender minorities usually support and are inclined to use online services and new technologies.

You also mentioned that, Dr. Wasserfall. You recommend that the Government of Canada support the implementation of digital health initiatives to improve access to sexual health care for LGBTQ2 individuals. In your opinion, what would be the impact, if any, of increased use of telemedicine or digital health initiatives to access various types of health care for LGBTQ2 individuals in your regions?

Dr. Tinus Wasserfall: I work in downtown Vancouver, so it's easy, right? The physical location is easy and I alluded to that.

In any case, in health care, we're on the cusp of a big technological revolution. It's going to happen in the next 10 years. It's slowly happening now, but I predict we're going to see major changes in health care in general in how we use technology and how people are treated. Health care providers will still be there, but it's about how we interact with technology and how we deliver care.

I talked about the patient medical home, which I feel very strongly about. I truly think this is a virtual patient medical home, whether it's for trans kids or for gay guys who live in Firefly, B.C.—if there is a place called that. I think that's really going to be the future. I really think that's an important initiative to look at for the future, that we have virtual online resources for this group to access care in an appropriate way.

Going back to PrEP, I don't think we should have any new HIV infections in this country. I think it's unacceptable. PrEP should be available, but I do hear from my patients that some of their friends live in small places where their health care providers don't even know about PrEP and don't want to prescribe it. They say to use a condom instead, or whatever.

That's another thing I want to tie in. I really think that technology is going to be super important in the future, both for support for health care providers and for the patients on different levels.

Social networks—

Mr. Robert-Falcon Ouellette: I only have about two minutes and 30 seconds left. I have a question about newcomers, and maybe Crystal or Dustyn can talk about that.

Let's talk about the mental health of newcomers who are in the LGBTQ2 community and young people who are dealing with parents who are perhaps new arrivals and they are first-generation Canadians.

We haven't talked much about that. Can you give us any insights into the needs of that population?

Ms. Crystal Fach: I have a background in working with newcomers as well. There's an intersectional layer of oppression there. We need more services to be provided in an anti-oppressive way. A lot of times when we go to settlement agencies, we have translators, for example, and we don't know who.... A lot of times those folks are coming from those communities and those communities are small and they know families. Sometimes the barrier to accessing support can be the settlement worker or the interpreter. We need to do more work on anti-oppressive training.

We also need more organizations that cater to newcomer LGBTQ youth. I know OCASI does some of that work, and there are pop-ups. In Windsor we have a few folks doing that stuff as well.

There are also safety factors that come in. I know that recently—and correct me if I'm wrong—something was passed whereby LGBTQ rights will trump religious rights in certain situations.

How do we navigate that while still allowing those youth to keep their faith intact? There's dignity in that, and I think sometimes we're forcing folks to choose between those two things. We need to do more education where we can allow people to have multiple identities in one person. I'm not just a queer woman; there are lots of other things about me. I think that's where the services and the wraparounds need to be more inclusive.

Mr. Dustyn Baulkham: I have a specific example from a recent refugee who joined us in Kelowna. He was our grand marshal last year. He'd fled Syria. Ever since he was in the news for being a grand marshal and sharing a story, he's been getting hate messages online from his own country and from his family. Obviously, he can now never go back. I don't think he's getting the proper resources and support that he needs to come to terms with that.

I know we're getting a few more refugees in Kelowna as well. They're LGBTQ2 identifying, and it will be interesting if they have those similar experiences.

Mr. Robert-Falcon Ouellette: Do agencies have enough supports for newcomers?

Mr. Dustyn Baulkham: No, they don't, specifically for LGBT. I know they're really lacking in that sense. He didn't even go through the main organization that we have. He went through Rainbow Refugee.

● (1655)

The Chair: The time is up.

Thanks very much.

Now we go to Mr. Richards.

Mr. Richards, we're all learning a lot here, so feel comfortable.

Mr. Blake Richards: Thank you. I appreciate that.

We didn't have a lot of time. It seemed to go by just like that.

I really did appreciate the answer you gave at the end, Mr. Baulkham. I think it was very well put that government tends to not lead the parade, but follows the parade. Certainly the work of many people to advocate and push the government in the right direction is needed, as it is true in many things.

Having said that, we were sort of in that conversation about the looking back piece. Do any of the rest of you want to add anything to what was said, or do we want to now look ahead?

Ms. Fach or Dr. Wasserfall.

Dr. Tinus Wasserfall: Is it still whether this government or society that led change?

Mr. Blake Richards: That's what I'm kind of trying to ask. Do you think the progress and the change that we have seen was led by society or do you think it was led by organizations or the government?

Dr. Tinus Wasserfall: At the grassroots level, it's probably led by society.

I'm not being political here. I don't know any of your political affiliations. I remember Jean Chrétien said that a minority right is not a majority vote. I think that's the way politicians can also make a big difference. He was talking about gay marriage; that's what he said and he put through the legislation. I do think it's grassroots level, but I think you guys as politicians are super important in making things happen as well.

Mr. Blake Richards: Ms. Fach, do you want to add anything or does that pretty much concur with the others?

Ms. Crystal Fach: I agree with exactly what you just said.

Mr. Blake Richards: Okay, let's look ahead.

Ms. Fearman, I know you had comments you wanted to make, so we'll start with you. Then we can go to any of the others.

I heard a lot of different things, besides some of the stories that you told me. Ms. Fach, you told about your tragic story of your friend. Mr. Baulkham, you talked about TransParent Okanagan. Things like that are all progress, but I heard that 42% of gay and lesbian teens attempt suicide at some point. I forget who talked about this; I could be wrong with what I heard. There are obviously higher rates.... It was mentioned about higher rates of alcoholism, drug abuse and all these things.

I'm going to make an assumption that this probably relates to—it might have been Dr. Wasserfall who said it—the longer someone isn't who they are, the more likely things like that will be the result.

Obviously, there's a lot of progress that's still needed. Looking ahead, what is needed for more progress? What do organizations like the ones you're part of need to do? What does government need to do?

Ms. Fearman, we'll start with you because I know you had some things you had wanted to say.

Ms. Loretta Fearman: I think funding for smaller organizations in smaller communities is absolutely necessary. For me, in this area, it's the Gilbert Centre. They're supporting the whole community. We need to ensure that there's funding for those organizations. That's one thing.

I don't want to take up all the time.

Mr. Blake Richards: I understand.

I know we've had some things mentioned about the health care system in particular. There's quite a bit of that. Obviously, that's more of a provincial jurisdiction. I'm not saying don't talk about that, but are there things specifically that would fall federally?

Mr. Baulkham, you can go for it, and then Dr. Wasserfall, maybe you would like to follow.

Mr. Dustyn Baulkham: Crystal said something earlier around a lot of pride organizations being cisgender, which is true. I think it's funding those organizations that are run by people with the actual lived experience in that situation. If we're talking about trans health, then it should be a transperson who is leading that. We should be funding those types of organizations because then you have the experts doing it, not someone who has no experience. They might have other experience, but not the important part.

Ms. Crystal Fach: In that stat you were quoting, it was 45% of trans folk who attempt.

Mr. Blake Richards: Thanks for correcting me on that. I wasn't sure I had it right, and I obviously didn't. Thank you.

Dr. Tinus Wasserfall: Once again, this is from Vancouver and our local health authority. Moving away from mental health disease, which is a thing on its own that needs resources, to moving to mental health wellness, which really is where you want to have the folks be before they move over to that, we do luckily have some programs looking at that.

Our health authority runs specifically for men, once again, 12-week programs on different topics such as mindfulness, yoga or mental well-being. That's really important. The initiative that I've seen locally has really helped people. It's just starting, but it's been amazing. I think that would be for all groups.

● (1700)

The Chair: The time is up.

We'll go to Mr. McKinnon now.

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

Thank you, all, for coming.

Mr. Baulkham, you indicated you were puzzled why you're here. I have days like that.

Of course, we're interested in hearing from people who have lived experience and expertise in this particular subject matter. You indicated in your testimony that one of the problems that you saw—and Dr. Wasserfall mentioned this in his first story—is finding organizations that are aware and sensitive to the particular needs of LGBTQ2 people. Dr. Wasserfall called it a medical home.

I was wondering if you can suggest, starting with you, Mr. Baulkham, ways that organizations can self-identify to signal to people that they are the right place to go.

Mr. Dustyn Baulkham: I don't know if there's one silver bullet on what that looks like. I think from a health perspective, I said there were some type of.... Maybe it's a training system, and that might be better for you to talk about to get that knowledge they need.

Maybe there is some type of—I don't know—certification, so they have at least the baseline knowledge of the LGBT community. That way I can look and know they're going to have a general sense as to my needs, to my friend's who's trans, or whatever that may be. They can provide the appropriate referrals.

I think, even from my pride hat, it would be nice if someone reached out, and there were some type of directory or something that I can go and look at and know that there's this specialist who has this expertise, and they understand the LGBT community because they've taken *x*, *y*, *z* training. I think that's a lofty goal, but it's something for us to strive towards so that we can all get the support and resources that we need.

Mr. Ron McKinnon: Would that be a certification program of some kind with some sort of sticker for the door?

Mr. Dustyn Baulkham: Well, I'd say more of an online directory than anything, because then you could obviously search it.

We talked earlier about the medical area changing and being able to do teleconference with practitioners. I think that's a great way for us to get that specialization that we need with people who have education on the LGBT community.

Mr. Ron McKinnon: Dr. Wasserfall, would you like to comment?

Dr. Tinus Wasserfall: I would reiterate what I said before. I think basically at every level of any kind of health care professional, there needs to be some baseline training on being sensitive to the LGBTQ community and their interactions with them.

Of course, you're going to get more specialized health care professionals or organizations. For us, we work in tandem with community organizations, so it's not just a pure medical clinic. There are different levels, I would say.

Mr. Ron McKinnon: Would anybody else like to comment?

Ms. Loretta Fearman: Yes. Perhaps I could mention the Gilbert Centre, which is an organization that we have here in Barrie. It's a small organization, but they offer community training. They will go to hospitals. They'll go to the police department. They'll go to any company—they go to Tim Hortons—and they'll educate the employees, owners and managers, doctors, lawyers, whomever. That helps a lot. If you could have that kind of training ongoing, that would be great.

Ms. Crystal Fach: Locally in Windsor there's an amazing organization called W.E. Trans Support. They've trained all of the hospitals. They've done a whole facilities audit. They also put up a poster that's an accountability clause, that says, “If you haven't been given gender-inclusive service, please contact us at...” That becomes a partnership between W.E. Trans Support and the hospital. It's that middle ground of bringing in an advocate from the community to navigate this situation. I think those will also help people feel safe, because just putting up a sticker or saying you took a course doesn't mean everybody in your organization's going to be a safe person. Having that accountability clause is also super important, as is partnering with a local advocacy organization.

● (1705)

Mr. Ron McKinnon: Thank you. Those are my questions.

The Chair: Thanks very much.

Now we go to Mr. Davies for the very last questions.

Mr. Don Davies: Thank you.

Just for the record, the change of law in gay marriage was really due to the courage of gay couples in this country who took the matter to court. Actually, it was the Ontario, Quebec and British Columbia courts of appeal that struck down the traditional definition of marriage between a man and a woman. That paved the way. That compelled the federal government to eventually pass a law that was then referred to the Supreme Court of Canada. So really it was the grassroots and I think the courage of gay couples that resulted in that change of law. No government or politician should take credit for that.

Dr. Wasserfall, we've heard evidence—I'm not sure if this is correct—that the poorest indicium of health is among people reporting to be bisexual. Do you have any evidence to give on that?

Dr. Tinus Wasserfall: Yes. If you just look at new HIV infections, the people who most commonly infect other people with HIV are the people who don't know they have HIV. Generally, somebody who's really well engaged in health care, let's say a gay guy, gets checked regularly. Now there are online resources. There are other ways of doing it that are low barrier where they can just get tested. But generally it's this population that is out of reach. They don't engage because they don't want to disclose they're having sex with same-sex partners. They don't get tested. They get infected. They don't know they're infected with HIV or syphilis or gonorrhea or any of the others, and they keep on going. It's an ongoing thing.

So definitely from a sexual health-wise point of view—

Mr. Don Davies: Would there be a similar dynamic with bisexual women? Would they also fall in that category of particularly poor health outcomes?

Dr. Tinus Wasserfall: Of course, women behave better....

Voices: Oh, oh!

Dr. Tinus Wasserfall: No, I'm kidding. That's—

Ms. Crystal Fach: We do. No, we just hide it easier.

On that, too, I think you're going to see it more in men because there's way more of a stigma. Because women are so sexualized, when coming out as bisexual, people are like, “Oh, cool.” There's slut shaming and a whole bunch of stuff added to it, but there's not that stigma that men have about coming out as bisexual. Just as with gay men, it's a different way of coming out. I think what you're saying is pretty accurate with men.

Dr. Tinus Wasserfall: Definitely we see that racially, among visible minorities. In Vancouver we definitely see that among people of the non-Caucasian race who are bisexual.

Mr. Don Davies: Again, there's an intersectionality that compounds it.

Dr. Tinus Wasserfall: There's a cultural component to this one.

Mr. Don Davies: My last question is for you, Ms. Fearman.

You talked about the wait-list. I think we heard evidence that there's only one hospital in the country for gender assignment surgery, and that's in Montreal. I'm curious about what the wait-list for surgery looks like in Canada. How many people are waiting for this surgery? I know your recommendation was that there be, I think, a hospital in every province for gender assignment surgery. Is there a demand for that? What is the wait-list like?

Ms. Loretta Fearman: The last I heard, just two weeks ago, the wait-list is two years for Montreal.

Mr. Don Davies: Do you know how many people are waiting in Canada for that surgery?

Ms. Loretta Fearman: That I do not know.

The Chair: Your time is up, Mr. Davies.

Mr. Don Davies: Thank you.

The Chair: I just want to say that we're so lucky to have the witnesses we have. You put all your cards on the table. You tell us your most intimate secrets. We're so grateful, because it helps us understand the challenges you face. Of all the people we get to hear from, the groups we're hearing from now are the most heartfelt and the most meaningful. On behalf of the committee, I want to thank all of you.

Ms. Fearman, I know it's difficult to do what you've done, to sit here in front of a camera all through this, but you've done a great job. I noticed that you left us for a few minutes, but you came back.

Anyway, on behalf of the committee, thanks very, very much for sharing your views and stories and for helping us understand this. Hopefully, we can help shed a little light on things.

With that, I adjourn the meeting.