HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 142 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, May 7, 2019

Chair

Mr. Bill Casey

Standing Committee on Health

Tuesday, May 7, 2019

● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome to the 142nd meeting of the Standing Committee on Health.

Pursuant to our study on LGBTQ2 health in Canada, we welcome our guests.

I'll just point out that the Conservative members aren't here yet. There's a little ceremony going on in the House for one of their members. They'll be right along, but I think we'll start to make sure we get everything in.

I will introduce our guests. From the Canadian Professional Association for Transgender Health, we have Jack Woodman, president. From KW Counselling Services, we have Washington Silk, a registered social worker and psychotherapist, and OK2BME program coordinator; and Scott Williams, who is the communications and development coordinator. From the Provincial Health Services Authority, we have Lorraine Grieves, provincial program director with Trans Care BC; and Quinn Bennett, provincial lead for peer and community support networks with Trans Care BC. As well, from YouthCO HIV and Hep C Society, we have Sarah Chown, the executive director.

Each group will have 10 minutes for an opening statement.

We'll start with the Canadian Professional Association for Transgender Health, Mr. Woodman.

Jack Woodman (President, Canadian Professional Association for Transgender Health): Thank you, Mr. Chair and members of the Standing Committee on Health for inviting me to speak today about the health and well-being of transgender and gender-diverse Canadians.

My name is Jack Woodman. My pronouns are they/them. I'm the president of the Canadian Professional Association for Transgender Health, CPATH.

CPATH is an interdisciplinary health professional association of over 600 members. Our vision is a Canada without barriers to the health, well-being and self-actualization of trans and gender-diverse people.

CPATH is a volunteer-led organization, and in my day job I'm the chief strategy and quality officer at Women's College Hospital in Toronto, which is Canada's first publicly funded academic hospital to offer a gender-affirming surgery program.

I'm a genderqueer Canadian, and so this work and the efforts you are undertaking in this first national LGBTQ2S study hold a distinct passion and purpose for me and my community.

Today I'll use the word “trans” as an overarching term that includes a wide range of people whose gender differs from the sex that was assigned to them at birth. The term “trans” may hold a broad spectrum of identities such as transgender, genderqueer, non-binary and two-spirit; however, not all individuals with these identities identify as trans.

You can see that we're already navigating expansive realms where gender exists well beyond a binary of male/female and doesn't fit nicely into two check boxes. The good news is that we're beginning to catch up. Since 2017, our Charter of Rights and Freedoms identifies gender and gender expression as prohibited grounds for discrimination and, as of 2018, Canadians can indicate they do not identify as male or female on their passports.

The future will most certainly include more expansive ranges of gender diversity. It will be a future where notions of presumed gender and expected behaviours and identities based on sex at birth will be old and obsolete ideas for the next generations of Canadians.

It's estimated now that there are 25 million transgender people in the world. Consider that close to 12% of millennials identify as trans. In Canada, a conservative estimate of 0.6% suggests that there are approximately 200,000 trans individuals aged 18 or older living in Canada.

There has been exponential growth in the number of trans people seeking health care, perhaps due to greater public awareness and acceptance of trans issues and greater connection and availability of information via the Internet. Reports on numbers of trans youth being served are indicating fourfold increases per year. In Ontario, there has been exponential growth in those seeking gender-affirming surgeries.

I want to emphasize here that not all people who are trans want or require surgery, or a medical intervention at all for that matter. For those who do require surgeries to optimize health, the range of procedures is very individualized. The numbers are quite astounding: In 2010, there were 59 approvals for transition-related surgery. In 2016 we saw it grow to 216 approvals. Last year, in 2018, the number grew to 1,460 approvals in Ontario alone.

Canada has just one small private surgical centre located in Montreal offering transition-related surgeries that include genital surgeries. Wait times are typically over two years to consult, let alone access to in-country services, and insurance coverage differs widely across the country, creating a sort of provincial lottery based on where you live. Imagine any other surgery deemed medically necessary that improves and saves lives being offered at one small private clinic in one province with vast variability in coverage depending on where you live.

Travel to and from surgical sites and lack of access to local surgical aftercare pose additional barriers and increased risk.

I'm incredibly excited that Women's College Hospital launched a new surgical program in Ontario last year that will broaden its scope of services to include vaginoplasty by June 2019. British Columbia is now poised to open a program in western Canada, and we are rising to the challenge to meet the health service needs of trans Canadians with an eye to offering services closer to home.

While universal access to health care is a tenet of our health care system, in reality this has yet to be reconciled for trans people, many of whom face barriers when seeking both general care and also gender-affirming care. Barriers range from lack of provider knowledge on trans issues to stigma and refusal of care. An estimation of health care inequalities between trans and cisgendered individuals in Canada highlighted that 43.9% of trans people reported unmet health care needs in the past year compared to 10.7% of the cisgendered population.

We know that many trans individuals underutilize or avoid health care services altogether, and there are lots of reasons for that. Of those who had accessed emergency departments while expressing a gender different from their birth-assigned sex, 52% experienced negative treatment due to being trans, ranging from insulting or demeaning language to outright refusal of care.

● (1535)

Understanding what prevents trans people from accessing health care—including stigma, environmental, social, policy and legal barriers—is crucial for improving health and well-being.

I understand that the committee has previously heard presentations that included evidence on health outcome disparities, including the crisis-level suicide attempt and completion statistics, with transphobia, lack of health care access, and low levels of family and social support creating the highest risk for suicidality. I won't go into more detail on this here, but I will emphasize that the social conditions that produce these health disparities are critical.

I now have a few recommendations to improve health and health care for trans and gender-diverse Canadians.

The first is to amplify the federal government's role in ensuring equitable health care access for all trans Canadians. Access to gender-affirming care, such as surgery and medications, is limited by variability in provincial funding that sees coverage in some provinces and not in others. A national body to review and support provincial and territorial efforts to serve trans populations equitably should engage all levels of government. It should be inclusive of trans people with diverse lived experiences, policy-makers, researchers, service providers and community leaders responsible for health and social services. With consideration to federal transfers, provinces and territories could be required to include provisions for improving access to and coverage of medically necessary gender-affirming health care—which currently places an undue burden on trans populations who generally experience lower socio-economic status and greater barriers to employment, and of course extended health benefits.

The second recommendation is to eliminate conversion therapy across Canada through legislative means. Gender conversion therapy is an intervention aimed at changing a person's sexual orientation to heterosexual and/or a person's gender to cisgender. Evidence consistently rejects this type of therapy as ineffective, harmful and unethical. Conversion therapy should not be allowed to continue with the support of public funds or under Canadian law.

The third recommendation is to strengthen and fund research, data capture and analysis on the health, social, economic and policy factors that impact trans Canadians. Trans health and health service data is critical to drive evidence-based policy and practice shifts within the Canadian health care context. Government data collection and informatics should inclusively capture the gender demographics of Canadians and be used to address health inequities. Health surveys and forms should not only represent male and female genders, but should be inclusive of capturing non-binary, trans and intersex populations. Just of note, our research committee recently completed the CPATH ethical guidelines for research involving transgender people and communities in 2019. As interest in researching trans experience increases, these ethical guidelines should be considered and applied.

The fourth recommendation is to implement a national gender diversity education strategy. A national education strategy that decreases stigma and promotes understanding of gender diversity and the safety, health and well-being of trans children, youth and adults should be supported and funded in all public sectors and at all levels of government, as well as the general public. Such a strategy also presents an opportunity for trans-inclusive sex and gender education from elementary schools to health professional programs at universities and colleges.

Finally, the fifth recommendation is to shift the balance of power to give more voice and power to the people with lived experience and ensure an intersectional approach. This means inclusive planning and co-design for equitable policy, research, education, services and supports. Our work at CPATH has been strengthened immeasurably by engaging and collaborating with those who have lived trans experience. To understand the factors that influence health and access to care amongst trans individuals, it's critical to consider intersectionality. In the trans context, stigma based on gender identity is often compounded by stigma based on race, age, sexual orientation, disability and socio-economic status. For example, higher rates of discrimination are experienced by indigenous transgender individuals, at 36%, than white transgender individuals, at 17%. These intersecting life circumstances create additional risks or marginalization for trans individuals.

Canada, as a human rights leader, has the opportunity and the responsibility to advance the health and well-being of trans people here in Canada, with reverberating impacts around the world.

Thank you—personally and on behalf of CPATH—for your invitation to present, and also for your study on LGBTQ2S health in Canada.

● (1540)

The Chair: I want to ask you a question. In your very first sentence you said, "my pronouns are 'they/them'". Help me with that.

Jack Woodman: When you introduced me, you introduced me as Mr. Jack Woodman.The name Jack has a masculine connotation in our culture. As a non-binary, transgender, queer-identifying person, I don't fall into a category of either male or female. Rather than using “he” or “she”, I choose to use “they” and “them”. It's quite common in the community to use they/them pronouns.

The Chair: When I introduced you, how should I have done it?

Jack Woodman: You could just introduce me as Jack Woodman. Different people use different.... There's an honorific “Mx.” that some people use, but just “Jack Woodman” would be great.

The Chair: Thank you.

In that case, next we have Washington Silk to make a presentation on behalf of KW Counselling Services for 10 minutes—or is Scott Williams going to do it?

Mr. Scott Williams (Communications and Development Coordinator, KW Counselling Services): We're going to go back and forth.

Washington Silk (Program Coordinator and Registered Social Worker, Psychotherapist, OK2BME, KW Counselling Services): Thank you, Mr. Chair and members of the standing committee. It is a privilege to address you this afternoon and take part in this historic study on LGBTQ health.

My name is Washington, and I am a transgender social worker and psychotherapist. I coordinate an LGBTQ program called OK2BME at KW Counselling Services in Waterloo region.

I'm here today with my colleague, Scott Williams, our communication and development coordinator, who is also a member of the rainbow community.

Mr. Scott Williams: KW Counselling Services is an organization that provides both walk-in and ongoing counselling to individuals, couples and families.

In 2005, we recognized that in order to best serve the LGBTQ2+ community we needed specialized supports, and the OK2BME program was born. We provide free counselling to rainbow youth aged five to 29, we have four different youth leadership and recreation groups, and we offer public education services that include providing free, ongoing support to our local school boards and their GSAs, or gay-straight alliances, as well as education and consultations to such organizations as our police force, hospitals, municipalities and local businesses.

We would like to share some data from Waterloo region. We are fortunate to have what we call the “OutLook” study, which is the largest study of its kind in Canada. It looked at levels of harassment, discrimination, victimization, outness, safety, isolation, inclusion, health and mental health care experiences amongst LGBTQ2+ people.

In this study we found that 42% of trans people and 30% of lesbian, gay or bisexual people had to move away from their friends and family because of their gender identity or sexuality; that 50% of trans respondents and 45% of cisgender, gay, lesbian and bisexual respondents experience verbal harassment in our community; that a majority of trans people, 72%, feel unsafe in hospitals, emergency rooms, medical offices and urgent care clinics; that 26% of trans respondents were either hit or beaten up because of their gender identity; and that a majority, 73%, of respondents said they feel they will die young.

Washington Silk: Mr. Chair and committee, my area of expertise is mental health. Simply put, when people are not treated well, they don't feel very good.

You've heard this before, and your other report has referred to it as “minority stress”. If I could explain minority stress as a math formula, it would be internalized homo/bi/transphobia, with the addition of stigma, the expectation of rejection and discrimination plus actual experiences of discrimination and violence. This equals minority stress.

Minority stress is directly linked to mental health distress and suicide. A recent report found that LGBTQ people and indigenous people in the Waterloo region have three to four times higher rates of mental illness and suicidal behaviour. This is why we need to change the landscape of our community and end homo/bi/transphobia and stop minority stress.

I'd like to share an example with you. Since 2005, we've helped start more than 30 GSAs in Waterloo region, in public, Catholic and private schools. As you know, GSAs are vital, offering psychological, social and physical protective factors for LGBTQ youth.

Today, young people are coming out earlier and earlier. I believe this is due to the shifting social and legal landscape in Canada. Research indicates that when young people come out, they often face victimization from their peers. This can have really lasting negative effects, given the developmental phase that teens are in. Because of our work in schools, we are presently surprised with the OutLook data, which shows that the majority of LGBTQ students receive supports from their classmates and teachers. In fact, and unfortunately, in Waterloo region, students receive more support from the schools than they do from their parents.

A recent study on GSAs in Canada was able to survey one-third of Canadian school districts and only a half of them reported having GSAs.

The well-being of LGBTQ people does not begin when they enter a doctor's office or my therapy room; it begins at birth. Having GSAs, resources and education to support LGBTQ youth is vital. This definitely includes the privacy of students being able to attend these groups without parental consent or knowledge.

Our counselling team supports many transgender clients. Often those who want to medically transition are not able to get the medical care they need from their doctor, so we do our best to help navigate the health care system and help them find the services they need.

I'm also often asked to write letters of support verifying someone's transgender identity before they're able to access medical service. This is sometimes known as a psychiatric or readiness assessment. I myself was asked to get one of these letters before I was able to access my own trans health care services.

As a social worker, I find this very odd. In no other circumstances do you have to write a letter to access the medical care that you need in Ontario. Like other health care services, trans health needs to operate on an informed consent model. Currently, too many people have to jump through hoops proving to often cisgender professionals, such as social workers or doctors who lack training, that they are trans enough in order to receive the medical care they need. This needs to change.

Effective trans care services include the patient-first, informed consent approach. It should not be left in the hands of me or a doctor to decide what somebody's gender identity is or is not, especially when research suggests that transgender clients are the ones educating their doctor—at 48%—or their mental health provider—at 53%—on what trans health issues are, in part because trans health is not included in formal education for medical or mental health providers.

We need to invest in our young people's well-being and their families.

I would like to share a story about myself. When I was 12 years old, I asked my brother if he would still love me if I were gay, and he said no. As you can imagine, I didn't talk about it again. I went away to university and I came back and decided that that was when I was going to talk about it, and so I told him. He took a deep breath and he turned to me, and he said, “Me too”. That means that we lived decades of our lives in silence. We weren't able to share a big part of who we were with each other, and it's not because our community was particularly homophobic or transphobic, it's because our identities just didn't exist—we were erased. There were no resources for my brother, for my family, or for me; and my story is not unique.

To me, one of the worst statistics, but not the most surprising that is coming out of the OutLook study, is that the majority of LGBTQ people have pretended to be straight or cisgender. They have erased who they are in order to function or feel safe in their community. I don't want another young person to have to erase who they are so they can get the medical care that they need, so they can go to school, so they can feel safe or so they can get a job.

We need to grow this idea of affirming supportive care and opportunities for LGBTQ youth across the country so that they can not only survive but thrive. This means that at a minimum we need to ban conversion therapy across Canada. We need to ensure that child protection workers, medical and mental health providers have adequate training and resources to effectively support LGBTQ youth and their families.

● (1545)

Transgender health care needs to operate on an informed-consent, patient-first model. We need GSAs to be supported in all schools across the country, LGBTQ content in the curriculum and comprehensive sexual health information.

I am proud to say that we are working to change homo/bi/transphobia in Waterloo region, knowing that just providing counselling in our community is not enough. We need to change how people are treated in our community, in order to improve their overall well-being. We knew we had to get involved in our community, with our schools, our police, our doctors and our businesses to try to create a community where no one is left behind.

Unfortunately, much of what we do in the OK2BME program is precarious, as our funding is not consistent or secure. I do not know what the future of my program will look like without adequate support and resources. I do know, however, that our holistic approach has benefited our community, and this is my ultimate recommendation to the committee.

Quite simply, we need to change our existing services, from data collection to the overall health care system, so we stop creating barriers and environments where people feel it necessary to hide or erase who they are, or worse, not get the care they need. We can change our data collection processes, but if people don't feel safe enough to identify, then the system change will not solve the problem alone. This also matters in hospitals.

In Waterloo region, and I suspect it's not different for the rest of the community, we know that 26% of transgender people have avoided the emergency room when they needed to access care, because of their gender identity. We need to start creating system changes that effectively support LGBTQ people, so they can feel safe and supported in every sector.

Our OK2BME program is an excellent holistic model for bringing change. I'd like to share that in the last year, we have helped get rainbow crosswalks installed in Kitchener and Waterloo; provided counselling to 454 individuals, families and couples; and 5,149 people have benefited from our youth group, public education and consultation services, all with very little funding, and a dedicated team.

Lastly, I want to share that the LGBTQ community is incredibly diverse in terms of both opportunities and inequities. That means that racialized, two-spirit, LGBTQ newcomers and individuals who live rurally may be further marginalized and disproportionately affected by inadequate health care and mental health supports. Targeted consultations, supports and resources will be needed to effectively support these communities.

Thank you for inviting us to this consultation. I hope you continue to engage with the diverse LGBTQ community, as you continue on this journey to improve the lives of LGBTQ Canadians.

Thank you.

● (1550)

The Chair: Thanks very much.

Now we go to Lorraine Grieves and Quinn Bennett of the Provincial Health Services Authority. You have 10 minutes.

Ms. Lorraine Grieves (Provincial Program Director, Trans Care BC, Provincial Health Services Authority): Thank you for the invitation to be here today. We're greatly honoured to have travelled here from Vancouver, B.C., where the two of us work on unceded indigenous territories of the Squamish, Musqueam and Tsleil-Waututh nations.

I'm Lorraine Grieves, provincial program director with Trans Care BC.

Mr. Quinn Bennett (Provincial Lead, Peer and Community Support Networks, Trans Care BC, Provincial Health Services Authority): I'm Quinn Bennett, lead for peer and community support networks with Trans Care BC. I'm also from the ancestral lands of my people, the Mi'kmaq on the west coast of Newfoundland, and I'm a trans and two-spirit person living in B.C.

Ms. Lorraine Grieves: I feel very privileged to be the program director, as a Cree Métis and British Columbian. I also identify as two-spirit, and am the proud parent of a 29-year-old.

We've submitted a brief for your reference, with 10 recommendations in it, and we'll be focusing our presentation today on health and wellness for transgender, gender-diverse and indigenous trans and two-spirit individuals in Canada.

Trans Care BC is a provincially funded program, created in 2015. We have a mandate to coordinate and improve trans health and well-being services across the province of B.C. The first of its kind in Canada, the program was developed to build and improve timely and relevant health care options for transgender British Columbians.

The work of Trans Care BC has been guided by the expertise of those with lived experience accessing gender-affirming care, along with health care providers and researchers. Trans Care BC's focus is on building capacity in the health care system, care provider education and increasing access to person-centred care closer to home.

As you've likely heard from other presenters, gender diversity is a natural part of human diversity that's existed across time and cultures. We're using the word trans today as an umbrella term, to include a wide range of people whose felt sense of gender differs from the expectations of gender based on the sex assigned to them at birth.

Mr. Quinn Bennett: We're often asked how many people are trans. This is difficult to estimate. However, prevalence estimates continue to rise. As Jack mentioned earlier, 12% of millennials identify as trans or non-binary based on a U.S. survey. Trans Care BC uses a prevalence rate of 1% to 3%, with 0.3% to 0.6% of people needing medical intervention related to gender transition. Even using current conservative prevalence estimates like this, the number of trans individuals in Canada registers in the hundreds of thousands. While many transpeople do not require gender-specific medical interventions to live comfortably in their gender, those who do often experience significant challenges in accessing this needed care.

Canadian researchers have documented high rates of harassment and violence towards trans adults. A national survey of trans youth revealed concerning outcomes surrounding mental health, psychosocial supports and access to care. Many transpeople in Canada have positive health outcomes, which can be attributed to strong support networks and access to health care, education, employment, housing and other services. Others lack the supports necessary to thrive. Gender-based marginalization can be magnified as a result of intersecting oppressions related to such factors as race, ethnicity, class and age.

Intervention is needed at multiple levels to address social determinants of health for all trans Canadians. Based on our expertise and experience in improving health services for transgender individuals in communities and the ongoing input we receive from those we serve, we offer recommendations for ways in which Canadian policy-makers can improve the health and well-being of transpeople in Canada.

● (1555)

Ms. Lorraine Grieves: In B.C. it has been essential to undergo policy, service planning and educational resource development work by including, consulting and directly collaborating with those who have trans lived experience. This includes youth, adults, parents, caregivers, indigenous trans and two-spirit communities. There are many other populations within trans communities who require dedicated planning and resources. These are refugees and newcomers, those living with disabilities, neurodiverse people and other who face increased barriers to care because of their unique intersecting identities and the social locations they experience. Understanding the diverse care journeys of trans individuals has been essential to our work as we address the most significant health disparities and inequities.

Through steering committees, focus groups, advisory committees, surveys and research projects, we've found multiple ways to engage and include a range of stakeholders in codesigning the work. By involving those with local lived experience, we've been able to attune our action plans as much as possible to the needs that are being identified. We recommend that work undertaken to improve trans health in any jurisdiction should involve those impacted directly, including trans individuals and their loved ones with diverse lived experience. Families and loved ones bring critical information to the planning process, as do care providers, in a networked approach to planning and implementation.

For the rest of our presentation, we'd like to highlight issues on access to care. There's much data to show that transpeople in Canada experience barriers to basic services. By this we mean general health care, employment, education, housing and so on. Providing name and gender marker changes without special requirements, inviting self-identification of gender and pronouns, removing gender markers from government identification, providing gender-affirming care to individuals who are incarcerated and adding gender identity and expression to human rights codes can improve service accessibility. Many trans Canadians are benefiting from such policy changes; however, inequities still persist due to differences in provincial and territorial laws and inconsistencies in policy application.

Broad work is required to review trans inclusion and cultural safety factors related to all levels of government and public services. There are many groups doing this work on limited funding and support. Our program has been developing free online learning modules to begin to help address the education needs connected to this work. We acknowledge that this is just a beginning step and specific to B.C. We recommend that appropriate funding be allocated to the public system to support needs assessment, cultural safety education and actions to improve accessibility.

Mr. Quinn Bennett: Now we'd like to talk about gender-specific care and supports. Like people of all genders, trans and gender-diverse people need access to supportive primary care and other basic health services. This access can be improved by training and supporting the existing system of care to gain competency and culturally safer care. Some transpeople require gender-specific health care related to transition or gender-affirming goals. This can include hormone therapy, supportive counselling related to transition, gender-affirming surgeries, voice training and assessment related to some of the more irreversible interventions.

Trans individuals who require gender-specific health care, such as hormone therapy or gender-affirming surgeries, frequently experience barriers to this care. Stigma, discrimination and gender-based harms in our health care system result in avoidance of care, directly contributing to health disparities. Improvements are needed in timely access to endocrine care, surgical care, psychosocial care and peer support services for transpeople and their families. In order to make a measurable difference to this issue, we believe a strategy is required. We've been lucky enough to have resources to work comprehensively in B.C.

In order to make national improvements, we suggest that federal opportunities for enhancing the work be funded. One idea would be to work with a group such as CPATH to create a well-supported national network of provincial and territorial coordinating bodies or key service providers and programs responsible for trans health work. For example, these groups can include Trans Care BC and Rainbow Health Ontario. There are strengths in every province. It would be of great utility to be able to leverage these strengths to improve care across the country. The national network, with peer support and convening dollars, could create an aspirational framework and/or national standards to support provincial and territorial work to ensure that trans populations are served equitably across Canada.

Ms. Lorraine Grieves: Lastly, we want to highlight the diverse needs of gender-creative and trans children, youth and their families.

Psychosocial care, peer support and access to health care are key determinants of health for trans and gender-diverse children and youth. We know from research that many young people do not feel it's possible to tell their health care providers about their gender if they are trans or non-binary. Even worse, sometimes they face latent discrimination in care settings, thus disengaging them from future care.

Service providers who work in trans health across Canada have been discussing the increase in requests for care from trans and gender-questioning young people and their families. Many providers have seen a tripling and even a quadrupling of requests, and that's just in the last year or two.

All youth need attachment to supportive health care and services. A smaller, but significant number of youth require access to gender-affirming medical interventions, and many experience barriers when attempting to access this care.

Research demonstrates the critical role that parent and family support plays in the lives of these young people. While many families are supportive of their children, some struggle to understand and accept their child's gender. In some cases, family rejection leads to homelessness and other negative health outcomes.

Support services of all types are needed for children, youth and families as they navigate their gender journeys. The western world is generally built for cisgender people, and anti-trans bias and related harms have been well documented in literature.

Due to this enacted stigma, when unsupported, trans youth face higher rates of mental health concerns, such as suicidality, anxiety and depression. When connected to timely and effective supports, many of these concerns are seen to be alleviated.

Counselling and peer support are low-cost, high-impact interventions, essential for improving the health and well-being of kids, youth and families.

Greater engagement of youth and parents is needed in guiding cross-ministerial approaches to ensure that policy, education, services and funding are in place to support gender-diverse and trans children and youth across all environments, including home, family, health care services, social services, other government services, school, community services and peer support programs.

Many programs serving gender-creative and trans children, youth and families have been eked out of existing services that were never originally planned to serve this population. Because of this, many are now overextended and inadequately resourced. As a result, children, youth and families are challenged to access timely care, and often they travel great distances to access the more specialized supports.

Time-sensitive, closer-to-home access for gender-creative and trans kids and youth is critical and potentially life-saving. Addressing this need nationally should be of the highest priority.

In summary, we thank you for the opportunity to present today. We've been fortunate to be able to do this work on a provincial scale, and we'd be very happy to share our learnings from this. We welcome any questions about our presentation or the brief we've provided.

Thank you.

● (1600)

The Chair: Thank you.

Now we go to YouthCO HIV and Hep C Society, and Sarah Chown.

Ms. Sarah Chown (Executive Director, YouthCO HIV and Hep C Society): Mr. Chair and members of the standing committee, my name is Sarah Chown. I am a settler on the unceded ancestral lands of the Coast Salish peoples, and I use the pronouns she and her.

Since 2015, I have worked at YouthCO, a youth-led agency that addresses the impacts of HIV and hepatitis C stigma. We use peer education and peer support to connect with indigenous youth, youth living with HIV and hepatitis C, and queer and trans youth.

While our organization's mission is about HIV and hepatitis C, these viruses disproportionately affect many LBGTQ2 people. For us to address HIV and hepatitis C, we must consider the broader health and well-being of queer and trans youth. This is what brings me here today.

This afternoon, I will talk about the experiences of youth in our programs who are queer and trans, and who may also be indigenous and/or living with HIV.

Before I can do these things, I must share my first recommendation with you: This study must heed the calls to action of the Truth and Reconciliation Commission. Specifically, as per call to action 18, this committee must recognize the impact of colonization on the health of indigenous peoples today, and implement aboriginal people's health care rights. This committee should seek the continued participation of indigenous queer, trans and two-spirit people as it moves forward. At a minimum, this includes incorporating LBGTQ2 narrative and research from and by indigenous people.

Many indigenous people are queer and trans, and this has been true before these words even existed in English. In the LBGTQ2 acronym, the 2 stands for “two-spirit”, an English word introduced in 1990. Métis scholar Chelsea Vowel tells us the term was chosen by indigenous people to be a “"pan-Indian" concept [encompassing] sexual, gender and/or spiritual identity.” It does not replace terms and teachings from each unique indigenous nation, nor is it a word all indigenous people who are queer and trans use to describe themselves.

To speak about indigenous youth, we must name past and—as importantly—ongoing forms of colonization. In what is now called Canada, colonization has deprived generations of youth of the chance to learn in and from their own families and communities. Without these opportunities, some communities no longer have pre-colonial knowledge about the role of two-spirit people or the words in their language to describe these identities. Upon arrival, colonial powers imposed overt transphobia, homophobia and biphobia, the belief that it is wrong to have gender roles outside western norms of men and women, and the belief that people can only be straight and cisgender. Together, these concepts can be referred to as “cissexism and heterosexism”. Both refer to prejudice towards queer and trans people. Due to these beliefs, colonizers also actively persecuted two-spirit people.

As a result, today's indigenous youth may not know that in many communities, two-spirit people were an important part of indigenous life, and they may not have two-spirit role models. Limited access to two-spirit teachings and community can be an isolating experience and have direct impacts on mental health. Without community support and adequate counselling services, substance use and suicide can become realistic options for young people. Combined, these structural factors and health inequities shape a syndemic—intertwining, mutually reinforcing epidemics—that worsens the impact of any one of these factors and contributes to the disproportionate numbers of queer, trans and two-spirit youth who die preventably each year, whether by suicide, untreated HIV or as missing and murdered people.

In response, I recommend that the federal government fully resource indigenous communities to lead responses to the intersections of colonization, cissexism and heterosexism. As a non-indigenous person, I hope by sharing some of these needs, this committee will do further work to hear directly from more indigenous queer, trans and two-spirit people.

Whether or not we are indigenous, too many queer and trans youth are not getting relevant information about our health. Last year, my colleagues Ghada and Avery conducted a survey with over 600 high school students in more than 80 communities. We embarked on this work because we suspected many youth were not getting the knowledge they need to make informed decisions about HIV.

What we learned was disappointing. Forty-five per cent of students told us that their sex education did not recognize that their sexual and gender identities even exist. Practically, this meant many students were only learning about penis-in-vagina sex, which is not the only way queer and trans people have sex. Furthermore, it is not the type of sex that accounts for most new cases of HIV in British Columbia. Heterosexism and cissexism mean many educators are not equipped to talk about the sex that is relevant to all their students, and as a result many queer and trans youth are not getting safer sex information.

● (1605)

In our survey, 84% of students agreed that school is an important place to get sex ed. Students told us they wanted sex education that is standardized, relevant to their experiences and delivered by someone who is knowledgeable and able to create safer spaces. Therefore I recommend the federal government implement the 2019 Canadian guidelines for sexual health education and fund community-led sex education classes and campaigns to bypass the current patchwork of sex education in this country.

Heterosexism and cissexism also mean that health information does not address queer and trans people and that queer and trans people are not always counted in research and surveillance data. Without this information, organizations rely on queer and trans people in our programs and on our staff teams to provide this information from their own experience.

At YouthCO, this approach to getting information has meant we have left out facts and context that are specific to trans, non-binary and two-spirit youth when it comes to HIV and hep C. One way we are responding to our shortcomings in this area is to advocate for research to include these youth. Without this research, trans, non-binary and two-spirit youth are not represented in the data governments use to fund interventions and services. I recommend the federal government ensures existing public health surveillance systems count trans, non-binary and two-spirit people within the ethical framework Jack mentioned.

The federal government must also ensure queer and trans people are updated on all surveillance systems and CIHR-funded research projects across health domains. With this new data and existing data about queer and trans health inequities, I recommend the federal government continue to introduce funding dedicated to queer and trans health beyond just HIV.

Now I want to talk about the queer and trans youth in our programs who are living with HIV. The stories of these young people have many threads in common. First, youth are not being offered information about HIV, or the medication that treats and prevents it, as part of their regular health care.

Second, youth who sought mental health or addictions support were not always able to find it. Too often, support was only available through private programs or after a long wait-list. In many cases, support that was available did not have the capacity to address queer and trans-specific issues. For example, many addiction facilities are divided into men's and women's programs and in these scenarios some youth are left to choose between being misgendered in the program or not getting the addiction treatment they need.

Housing and employment insecurity disproportionately affect queer and trans youth who are less likely to have safe families they are able to ask for help. These factors can push us to have sex or use substances in ways where we are more likely to come into contact with HIV. Many emergency housing options are also gendered, leaving youth to choose whether they will be safer on the streets, in a gendered shelter or spending the night as a sex worker.

I recommend that federally funded institutions that house people, like corrections facilities, shelters and addiction treatment programs provide gender-neutral options and be staffed by people who have received queer and trans competency training. This recommendation would address this syndemic that drives health inequities among queer and trans people today.

Queer and trans youth living with HIV worry that they cannot afford HIV medications if they leave British Columbia. This is one reason I recommend the federal government introduce a national pharmacare program. This program must ensure access to HIV medications as well as gender-affirming medications such as hormone therapy.

Across our work at YouthCO we encounter people who still have more misinformation than facts about what it means to be queer and trans and what it means to be living with HIV. Some of this misinformation comes from the current policy of the federal government, like the deferral period for male blood donors and the criminalization of HIV non-disclosure. This misinformation fuels stigma and makes it harder for us to talk openly about our lives and get the health care we need. As long as this is the case, health inequities for queer and trans people will persist.

Thank you for your time. I look forward to your questions.

● (1610)

The Chair: Thanks to all of you.

Now we're going to our question period. Before I start, I want to remind everybody we'll go in camera at 5:10 to do some committee business.

Ms. Sidhu, would you like to start us off?

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

Thank you all for being here.

I'm sharing my time with Shaun Chen.

Jack Woodman, you said that health services need to be improved by including LGBTQ2 and when we heard from KW Counselling Services they said we need to change the way of doing data collection.

Can you explain to me what kinds of initiatives are necessary?

Jack Woodman: I'll start; and KW, feel free to jump in.

In terms of the challenges, often in the surveys we'll be asked to identify our sex and it might just offer the options of male and female. As you've heard, across gender spectrum, that doesn't capture the diversity that exists in gender. Sometimes people will use terms such as “other”, but again, you're still missing a lot of that diversity. When there's actually an opportunity for people to self-identify their gender, that is very helpful. Sometimes people do ask the question, “What is your sex assigned at birth?”, which is often a less relevant question than gender identity.

The other thing nationally that exists, just thinking of my Porter flight here or whenever I'm asked to fill out a form, or with honorifics and that type of thing, is that I'm required to put in Mr., Miss, Ms. or Mrs., or Dr., which I can use sometimes as well.

Those things need to be considered, especially for health surveys, because that information about gender can then be stratified against health outcome information. That's really the critical piece: Can we stratify that information to see where there are disparities and gaps in our health?

Washington Silk: I just want to emphasize again that collecting socio-demographic data will lead to better health outcomes and how we deliver our services.

Changing the form is not enough, if we don't create a system where people feel safe enough or have enough information to self-identify. I didn't know what the word “transgender” was until I was in my late 20s. I would never have put that on my form when I was 12, because I didn't even know the word existed. My doctor didn't either.

It's not just changing the form. Yes, it's very important for health outcomes, but it's also about training our doctors. It's about training nurses on how to have our conversations, making it a part of our regular, everyday functioning society, because trans and gender non-conforming people are a regular, everyday part of our society, right?

My point is that the effort needs to be holistic. Does that make sense?

● (1615)

Ms. Sonia Sidhu: Anyone can answer this question: What about education? At what age is it necessary, when we are providing the education to the schools?

Ms. Lorraine Grieves: Education is needed broadly from the age of day care through to the rest of our lives. Young people get gendered and start getting put into those gender boxes right when they start encountering, sometimes at the hospital when we think about what people ask when babies are born: Is it a boy? Is it a girl?

Broad education at all levels is needed, from very basic through to more specialized, depending on the setting.

Ms. Sonia Sidhu: Thank you.

I'll pass it over to Shaun.

Mr. Shaun Chen (Scarborough North, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses today for providing some incredible testimony and for their passion on this issue.

I know a few of you are from Ontario, particularly Jack, Washington and Scott. My background is in education. Before coming to Ottawa, I was the chair and trustee of the Toronto District School Board.

I know in Ontario now the provincial government has scrapped the 2015 sex education curriculum, and with it, lessons on gender expression, gender identity, same-sex marriage, same-sex relationships and sexual orientation. There have been groups and individuals, ranging from the Canadian Civil Liberties Association to teachers, health educators, medical professionals, social workers, parents and students, who have come out very strongly in recent weeks and months against these changes imposed by the Ontario provincial government.

As people who work with the trans and LGBTQ community, can you speak to the impact of those changes within the Ontario education system on young people?

Washington Silk: First and foremost, we're going to expose young people to minority stress. From the get-go, you're being told you don't matter and you're being erased, which is directly correlated to mental health distress and suicide.

On top of that, the number of requests we have from the teachers has increased tenfold, because teachers no longer feel confident to support LGBTQ students. They're more worried about getting in trouble than the well-being of their students, and not all teachers by any means, but they're asking for outside support. We've been working for over 10 years to get to an amazing place with the school board, and I just feel as though it's a big step back.

Jack Woodman: Absolutely, I concur with that. What I'll add to this conversation, because my organization works with health care professionals, is that education through the entire trajectory into university and professional health care education is critical, because there's just so much lack of knowledge across health care providers that when trans and gender-diverse people are going to see them, they don't necessarily have the skills and knowledge that they need. In fact, one of my greatest career challenges has been the development of the gender-affirming surgical program at Women's College Hospital. To find surgeons to recruit and train at that level is very challenging.

Absolutely, across the whole spectrum of education we need to be promoting that. As Lorraine said, it's really from day care when we start gendering folks in that way.

Mr. Scott Williams: There's nothing to add, I don't think, to that.

Mr. Shaun Chen: There was some testimony about racialized and aboriginal communities. Can you speak to some of the gaps in terms of education when it comes to new immigrant communities and racialized communities? How can we do a better job at promoting that education within those groups?

That's open to anyone.

Ms. Lorraine Grieves: That's a big question. I'll start with indigenous communities, and I'll speak to the B.C. context, because that's where we're working. B.C. has 203 first nations. To begin to understand how Trans Care BC as a program can be relevant to the communities in B.C., we've taken our time to travel, to introduce the program and to try to understand by having direct conversations with people who will show up and meet with us about the intersections of colonization and gender and how colonization has impacted gender.

One story really stands out to me. We had a meeting in a community in the north and, on the way into the meeting, someone who's quite prominent, an elder in the community, was bullied by people outside the meeting saying, “Why are you going to that gay meeting? You shouldn't go in there.” The session then became around this conversation about this idea that they come and talk about trans issues or gender diversity—one was gay—and that the community just literally didn't have safety around being queer, trans, etc. That was directly related to colonization, histories of residential schools in that community and the idea that somehow being gay was attached to possibly a sexual abuse history. It's a very complex and very local understanding.

I think all of that work needs to be really attuned and tailored to the community that it's being addressed to. Similarly with newcomers and refugee communities, people come from a particular cultural understanding of gender and gender diversity, and there are both strengths and sometimes challenges to that. There are many examples of gender diversity around the world.

I'm also a clinical counsellor. I didn't mention that. Some of my conversations with diverse young people from different cultural backgrounds ask if they know about gender diversity in their culture. There are some very good online tools and maps of the world that we can explore and look at the history of gender diversity in Thailand, for example, or other places around the world.

I don't think there's a simple answer, but it's all about dialogical engagement of the people we're working with.

● (1620)

Mr. Shaun Chen: Thank you.

The Chair: Now we go to Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

Thank you to the witnesses for being here.

First I want to start by apologizing for our being late. I wanted to make you aware that one of our colleagues, Mark Warawa, who's the member for Langley—Aldergrove, has found out that he has cancer, and it's colon cancer that has spread to his lungs and his lymph nodes, so he was making his final speech in the House today, which was a very sad occasion, and that's why we're late.

I want to focus my questions, if I can, on some things that are specific to being transgender. We've been hearing a lot about LGBTQ health issues, but I want to see if there are ones that are particular and maybe different than the rest.

When it comes to having surgery conversion, are there any specific issues with respect to failed surgeries or complications that would be health issues that transgender people would experience that the rest would not?

That's for anybody.

Jack Woodman: I'll take that question.

Speaking to the surgical question that you're asking, there are complications, just as there are to any surgery. But the real complication for transgender communities is that there is not local care. Folks are often having to leave the province or leave the country to get surgical access, and then when they return, if there is a complication, there is not necessarily a provider or a clinic or a service that is able to address those locally. Then they may have to either return to that service or find somebody locally who maybe doesn't have that expertise. That's part of the program we're trying to build out in B.C. and in Ontario, but of course, there are going to be people from farther afield who don't have that access.

In terms of speaking to differing health outcomes and that sort of thing, there are a number—and I'll let my colleagues jump in on this—but the one that is often discussed from the research is the suicidality, which is not in fact related to being trans, because being trans is not a pathology in and of itself. But it is because of the social oppression that occurs, and what we do see is 23% to 43% of trans people reporting a history of suicide attempts. Obviously, mental and psychosocial support for the population is critical.

Ms. Marilyn Gladu: Is there any other input on that question?

Washington Silk: I just want to add a couple of items. One is wait times. People are most at risk of attempting or completing suicide when they're told to wait. You can imagine it as being under water your whole life and finally coming up for a breath of fresh air, asking a doctor or someone to pull you out, but instead they push you back down because they say they don't know enough or you have to wait. When you're ready to change, you've perhaps shed your internalized homophobia or transphobia, you're ready to be who you are, and no one's there for you. You're told to wait. You have to wait two years, you have to wait six months, you have to go talk to someone you've never met, share intimate details of your life, get it written in a letter to prove you are who you say you are. It's very difficult.

I do actually have some local stats that I think are very valuable. I'll just share a couple of them.

Some 76% of trans people had to educate at least four different health care providers about their own health care. I don't know any other situation that's very similar. Some 53% had to educate their mental health providers and 48% their family doctors, 40% the clerical staff, 39% their psychiatrists. Psychiatrists are the ones who have the power to give you the diagnosis. That's pretty serious.

In Waterloo region, we know that most people have a primary care provider, but at least 23% of the doctors said they don't know how to provide that care. So people have to go elsewhere. More than anything else, people avoid hospitals, emergency rooms, medical offices and urgent care because of their gender identity and how they're going to be treated, putting their lives at risk.

● (1625)

Ms. Marilyn Gladu: You mentioned there are long wait times. What is the wait time and how long does it take from the time you start hormone therapy until you can complete your surgical finality?

Ms. Lorraine Grieves: The pathways are really variable for people, so it's a really hard point to speak to.

I think, as you heard, the journey is very long for people. Often, someone might think for a long time about coming out and talking to a professional, and then the search to find that first professional can take a long time. Many people start with hormone therapy and then sometimes after a year, five years, 10 years—it totally depends on the individual—they might think about surgery. Some people will never access surgery. It really depends on where one is in any given province or anywhere in the country, because access is not even.

We found in B.C., as we've explored the client journey, that there are just many bottlenecks along the way and, in fact, big variation in clinical practice, in part depending on when people were trained. It's been really new work to start to bring together providers and people who access services to try to have more standard pathways and more clear standards of care.

For example, our B.C. patients are travelling to Montreal for the most complex surgeries, for genital reconstruction surgery, and then returning home. That wait can be—once the referral is in—anywhere from nine months to two years, for say, a vaginoplasty, which is one of those surgeries.

Ms. Marilyn Gladu: In the provinces that don't have the service, do they pay the Province of Quebec or whatever for the surgery? Does the patient have to pay and get it back?

Ms. Lorraine Grieves: In B.C. the genital surgeries are funded by MSP, which is our provincial insurer, and they have an agreement with the Montreal clinic to pay for services there.

Ms. Marilyn Gladu: I have a question for Sarah.

Talking about HIV and hep C, is there a difference between the trans population and the greater LGBTQ population in terms of frequency?

Ms. Sarah Chown: That's a great question.

I think the answer is that we don't have the best data to answer that question in a Canadian context. We know from the data more broadly that trans women and trans women of colour are disproportionately affected by both HIV and hep C. But we don't have Canadian data that says that at a national level, because the Public Health Agency of Canada HIV surveillance data doesn't include trans, non-binary and two-spirit as a specific category in what's recorded publicly.

Ms. Marilyn Gladu: Thank you.

The Chair: Mr. Davies.

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

First of all, I want to thank all of the witnesses for being here. I want to thank you for sharing intimate details of your lives. It's very powerful and I can tell you, you're educating us. I learn things every meeting when we talk. You're helping to change minds here, and I want to just point that out.

Jack, I had a number of questions for you to start with. In terms of gender transition surgeries, is there a significant difference in access between males transitioning to females versus females transitioning to male, or is it equally the same weight?

Jack Woodman: As I mentioned, there's only one clinic in the country right now that does genital surgeries, and that's in Montreal. We are, in Ontario, going to be offering vaginoplasty but not phalloplasty. In B.C. I believe they're going to be offering all genital surgeries on both sides of that binary.

My answer is no. There's poor access across the board.

● (1630)

Mr. Don Davies: Okay.

Ms. Lorraine Grieves: Can I speak to one point on that?

Just with regard to chest and breast surgeries, in many provinces there are really narrow criteria for trans women to access funded breast augmentation surgery, and often there is more open access for trans masculine people to get chest surgery. That's a discrepancy that's been noted in our context. There are far fewer breast surgeries than chest surgeries.

Jack Woodman: Thank you for saying that, Lorraine. I didn't mention that.

I want to add one point to that. Because of the variability across the country in which provinces cover which procedures and various people needing different procedures or are having different procedures, there are also, in upper surgeries, those who are having chest surgeries where some provinces cover a fuller procedure, which includes chest masculinization and not just breast removal, while other provinces don't cover that. There's just variability across all provinces in terms of what is covered, so that's a real challenge.

Mr. Don Davies: Thank you. I think you just illustrated to me the inappropriately binary nature of my next question. I was going to ask which provinces do and don't pay for gender transition surgeries, but it sounds like it would be a complex answer depending on the surgeries and the provinces.

Jack Woodman: Yes.

Mr. Don Davies: Are there any provinces that are not paying at all for surgeries?

Ms. Lorraine Grieves: On the east coast, I think it's a newly funded procedure.

Jack Woodman: New Brunswick.

It's very complex. I'll pull out a document here that I'll leave you. It's a map of what is publicly funded gender-affirming care across the country that CPATH developed with a union. It outlines it, because there are so many procedures as well. It's not like there's one surgery for this and one surgery for that. There are over a dozen types of surgeries that are included and each province has different ones that they cover.

Mr. Don Davies: Thank you. That will be helpful.

Washington, I'd like to ask you a couple of questions. One of them is—I was just thinking about this when you were all testifying—are the requests for gender identification on documents broadly speaking, passports and everything, as necessary as they are ubiquitous? I'm just wondering why we even ask. If you're applying for a passport, why do we need to put a check box for that? There's date of birth, name, picture. With your experience in having to fill out these very difficult choices, do we really need to have as many of those boxes as there are?

Washington Silk: I don't know how accurate that is in identifying who you are. For example, for me to travel here today I had my gender marker removed from my ID, which obviously we're happy about, but I can't fly with my ID anymore even within Canada because it doesn't have a gender marker, so I have to bring my passport and click on boxes that don't represent me.

It would be easy to say that's not a big deal, but it is a significant deal. It really wears on you.

The trans PULSE studies found that having one piece of ID in your affirming name, with your gender marker, reduced suicide ideation by, I think, 96%.That's significant, so I would happily remove all my gender markers.

Mr. Don Davies: So that's airlines requiring that identification? I wonder if this would be—

Washington Silk: I'm not sure, but—

Mr. Don Davies: What regulation requires the mandatory identification revelation of gender identity to access what is essentially a public—

Washington Silk: And beyond that, how do we adequately capture people who are intersex? That is erasing the identity of a lot of different people.

Mr. Don Davies: I am going to come back to you because I have limited time, and then we'll have another round, I think.

Lorraine, I think you used the term “neurodiverse”. Can you give us an explanation of what that means?

Ms. Lorraine Grieves: It's a term that gets used sometimes for those who would be on the autism spectrum, or have diversity in how their brains work. Interesting numbers are being seen in the research literature around those who are neurodiverse more prominently presenting as gender-diverse as well. Sometimes that presents a barrier for a young person in getting care, for example, because they will find there is much more gatekeeping around accessing gender affirmation because they may also have an autism diagnosis.

● (1635)

Mr. Don Davies: Okay, I see.

Ms. Lorraine Grieves: In the end, once those young people are assessed and get through all those gates, they're often affirmed in their gender and are allowed to be themselves.

It's an area of particular attention around working with young people right now.

Mr. Don Davies: Thank you.

Sarah, a 2015 meta-analysis of 21 Canadian studies on the health of LGBTQ2 youth found that young individuals from those communities are at greater risk of pregnancy than their heterosexual counterparts.

Do you have any ideas why that is, and any suggestions of how we can address that?

Ms. Sarah Chown: Yes, that's one of the things I had to take out of my 10-minute statement, so I'm glad that's already been presented.

I think the main reason is that health care providers make assumptions about who does and does not need contraception based on how people present their gender and sexuality, and those assumptions are often incorrect.

I also think that, as everyone on this panel has said, when queer and trans youth expect the health information that's being presented in their classrooms or by their doctors does not to apply to them, we stop paying attention. Even if contraception is covered in a gender-affirming way, which is pretty unlikely given the state of what we know is happening about sex ed, people might already have made the assumption and already listened to most of the sex ed that wasn't that relevant, so they stopped listening.

The Chair: Mr. Davies, your time is up, sorry.

Now we'll go to Dr. Eyolfson.

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

Thank you, everyone, for coming.

There has been some really amazing, and quite frankly, alarming testimony that we've heard during this study in a country where we consider ourselves a human rights leader, and yet we hear from people with some very shocking stories of how they're treated institutionally. We're hoping we can improve that.

Speaking from the point of view of the medical profession, I've heard a lot about how non-binary people, LGBT are having such difficult and bad treatment in the medical system. I am a medical doctor; I practised emergency medicine for 25 years. I witnessed some of that treatment.

This is open to anyone. What avenues...for advocating for changes? Have you been talking to medical schools or provincial licensing authorities or anyone? What else would be a good idea on how to address this with medical and nursing professions?

Ms. Lorraine Grieves: That's the point. We have been in conversation in B.C. with various professional bodies and with the medical schools, and in partnership with the UBC medical faculty and online, we've been building a set of online modules that will be CME accredited.

Most importantly, we're very interested in how to get this training into pre-service curriculum so we're signalling that this is a normal part of health care all the way through to those who are getting trained to be in those professions.

Mr. Doug Eyolfson: Good.

Are they receptive to what you're saying?

Ms. Lorraine Grieves: More and more so, and I think a lot of physicians are seeing more and more people present for this care in their practices. We've been barely able to keep up with the demand for training in our province. Actually, there aren't enough of us to train all of those reaching out for training by us.

Mr. Doug Eyolfson: Well, that's encouraging.

Ms. Lorraine Grieves: It really is.

Mr. Doug Eyolfson: It's not that you don't have enough, but that more people are reaching out.

Ms. Lorraine Grieves: Yes. We're working on a “train the trainer” network model so we can train more because some of the training has to be live training. Online modules only go so far.

Mr. Doug Eyolfson: Good.

With regard to more education, this is something I've always agreed with. I went to school in the 1970s and through most of it we didn't have any sex education. Whenever someone brought in a sex education program you would have crowds of angry parents bearing torches at the school and saying, “How dare you pervert our children with this stuff”, and this was long before we were talking about non-binary things.

It's still an issue. A teacher friend of mine in B.C. very recently was told as she was starting the year, “We don't talk about people being gay or anything like that. The parents around here are very uncomfortable with it. If a student asks, just say that we don't talk about that here.” This was very recently. And I'm seeing nods. Shockingly, no one is surprised by this.

Even for GSAs, there is a lot of resistance. We know what's going on in Alberta right now.

I remember in Manitoba there was a provincial ruling that schools had to allow GSAs. In one local community there were 1,000 people who showed up to protest this because they said this was treading on their religious beliefs, the belief that was prominent in this community. Again, we have a long way to go.

How do you address this resistance? I know there is still resistance in the public and among parents to schools putting in this kind of education.

Ms. Lorraine Grieves: We're grappling with this in B.C. right now. There's been a fair bit of organized protest to the rollout of GSAs, and we think there's a ton of research to support that work. In B.C. we have a research centre called the SARAVYC. It has been able to show, by linking health data with the presence of GSAs in schools, that we see health outcomes improve not just for queer and trans students but for the heterosexual male population in schools and the cisgender population. If we can get into dialogue with people, I think we have some compelling evidence to support GSAs. Sometimes some of these groups aren't willing to engage in that kind of dialogue, but it's a particular problem in a lot of provinces right now.

I do think it's a sign that we're making progress.

Mr. Doug Eyolfson: Good.

● (1640)

Ms. Sarah Chown: One thing that I would add, if possible, is that the federal government's role is really in creating policies that normalize the existence of those of us who are queer and trans and in representing us in things like the census and other federally funded pieces, and by normalizing our identifies. There is really a big role that the federal government can play in addressing that.

Schools are for students, and 84% of students in our province want sex education in their schools, and most of those students are not getting sex education that represents their sexual and gender identities. Anything the federal government can do to really normalize these identities, including providing information to newcomers and refugees about gender-affirming surgeries, for example, can really help to change that.

Mr. Doug Eyolfson: Okay, thank you.

The medical specialists I interacted with, those who had specialized training in human sexuality and were experts on these issues, have said the notion that being gay or trans was a choice has been thoroughly debunked. Even if it weren't, why would that be an excuse to mistreat someone? But it's not a choice. The science is clear on this. Do you still encounter people who claim it is a choice? Is that still a common view in the community among those with whom you interact?

Again, I'll leave it open.

Ms. Lorraine Grieves: Not prominently. I think some of those groups that were protesting GSAs in schools would probably be some of the same groups that would invalidate the identities we're talking about and would suggest that it is a choice.

You've heard everyone talk about conversion or reparative therapy. That's where if I were to come out as trans, a professional might work with me to try to convince me out of that. We've seen that do great harm. Ontario has made it illegal. Many professional bodies outlawed or condemned that practice because we know it does great harm. It's not a choice.

That's a minority position, I hope.

Mr. Doug Eyolfson: I'm pleased to say that at least my home province of Manitoba is one of the provinces that does ban conversion therapy, or at least does so for children. I think that's something that needs to be rolled out nationally, and not just for children. I agree with you on the harm it causes.

The Chair: That completes our seven-minute round. Now we're going to go to our five-minute round.

We're going to start again with Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I'm going to finish off my one question. I'm assuming that because we don't have specific non-binary analysis in the health care system for HIV and hepatitis C, the same is true for the STBBIs to try to figure out.... Okay, good.

The second question, then, is with respect to two-spirited persons. We've had quite a number of people have a go at defining what a two-spirited person is, and we've heard quite a range. I'm interested, Sarah, if you want to take a crack at what you think a two-spirited person is and then, Lorraine, if you could have a crack.

Ms. Sarah Chown: I would defer to folks in the room who hold that identity, unless you'd like me to go first.

Mr. Quinn Bennett: Sure, I can go first. I'll just speak from my own teachings and ideas around what two-spirit means for me, also recognizing that it's very different in different nations and depending on communities and what their knowledge is about two-spirit.

For me, it's really rooted in indigeneity and having both masculine and feminine energy or medicine that I carry in the community and also realizing that there are responsibilities. In some communities, when we've done our indigenous engagement work, we visited rural, on-reserve communities where we ask folks what they know about two-spirit, what their language is around two-spirit. We hear some really amazing stories about how two-spirit folks have been lifted up in their communities and seen as folks with opportunity to support the community in different ways.

Then we hear other stories in communities, which are more heartbreaking, around the loss of language or a lack of safety around talking about two-spirit, like the example Lorraine shared earlier about the elder trying to access a workshop and then getting pushed back from that.

For me, two-spirit is all about having an experience of both of those energies, also matched with responsibilities in my own community around that.

● (1645)

Ms. Lorraine Grieves: I'd say two-spirit is a really simplified English term to represent a set of very complex concepts. For me, in terms of my own position around being two-spirit, I've been following the breadcrumbs to figure out, first of all, my Cree Métis history and whether there is a word for two-spirit within the people who I come from. I've been able to track my ancestry back to a particular territory in Montana where there is, from the colonizers who came to that community and researched the community, a very long word that I can't pronounce within that Blackfeet community that my ancestors come from.

It's a very complex concept. There were women, folks who were assigned female at birth, who took up roles that were seen as more masculine in the communities, very capable women who could tan hides as fast as the men, who owned property and didn't lose their property when they married a man. They sometimes had multiple partners. That's how the anthropologists at the time described those two-spirit people. There's probably a richer history to all of it that predates the records.

For each person, there's an invitation to search back to the people that one comes from and to figure out if there was a gender-diverse part of the community and what that was about in that community. I think we'd find it's very different from nation to nation. That's what we've heard when we've engaged with two-spirit researchers or two-spirit people themselves. It's unique to the indigenous person and the community they come from.

It's very hard to pin down.

Ms. Marilyn Gladu: No, that's good. That explains why there's so much diversity in the definition.

Sarah, with respect to the indigenous people we heard, the intersectionality does have an influence on how people are experiencing it, especially with the indigenous population. I used to be the chair of the status of women committee. We were studying violence against women and girls, and we did also hear of huge violence issues against the transgender and LGBTQ populations.

I wonder whether you think it would be a good idea for the government to add that aspect to the murdered and missing aboriginal women inquiries and consultations.

Ms. Sarah Chown: There are two-spirit people in Canada who have been advocating for two-spirit folks to be included in the inquiry around missing and murdered indigenous women, because we know that a lot of that is related to gender, and two-spirit folks have their gender policed all the time by systems. There's definitely disproportionate representation of two-spirit folks in that. I think that would be an important issue to learn more about and respond to.

Ms. Marilyn Gladu: I have one more question. This is about conversion therapy. In the different provinces that have banned it or not covered it provincially, there are different definitions. Is there a definition that is favoured by the LGBTQ community?

Ms. Lorraine Grieves: Not strictly; I think it's just any therapy that's not honouring who an individual is and which attempts to erase or convert that person to a cisgender or heterosexual identity. I don't know of a sort of boilerplate definition that is being used commonly across groups or provinces.

The Chair: Thank you.

Now we go to Mr. McKinnon.

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

Thank you all for being here.

My riding is Coquitlam, so I'm going to focus on British Columbia here.

I understand, Lorraine, that genital surgery may be available soon in British Columbia. Do you have a time frame for this?

Ms. Lorraine Grieves: The clinic is supposed to open this summer, with surgery starting in the fall of 2019. It will be in Vancouver Coastal Health Authority.

Mr. Ron McKinnon: What barriers were faced or are yet to be faced in the establishment of this facility?

Ms. Lorraine Grieves: I think our next challenge will be making sure that people have a very safe and smooth journey both into surgery and out of surgery. There's a lot of work to do to train, because our province is large. People are coming from many communities to Vancouver, so there is also travel within province, but a great distance.

There is also the question of how to ensure that people are getting safe aftercare and supports closer to home when they are recovering, because it's a long recovery journey for the most complex surgeries, many months of recovery.

There is, then, a lot of training and capacity-building work to do.

● (1650)

Mr. Ron McKinnon: You indicated before that MSP covers surgeries, for example, in Montreal. Is it expected, then, that MSP would cover surgeries in this clinic as well?

Ms. Lorraine Grieves: These will be covered, and the door will remain open to Montreal, so people in B.C. will have additional options for surgery.

Mr. Ron McKinnon: Do you expect this to draw transgender people in the west to Vancouver, rather than their going east, for example?

Ms. Lorraine Grieves: At this time, it will be B.C. residents with MSP coverage who will have to access the Vancouver program. It won't have capacity to serve people from other jurisdictions.

Mr. Ron McKinnon: How will this improve the time frames that you mentioned before? You said earlier that it takes from nine months to two years, give or take, for trans people in B.C. to get service in Montreal. Is that going to change dramatically, or at all?

Ms. Lorraine Grieves: It should change over time. This program is part of an overall surgical strategy in B.C. to have appropriate wait times for all surgical services. This will be captured in that work provincially. It will take time to scale up, but over time the expectation will be that those surgeries fall into the standard benchmark. It will probably be considered what we call a priority 5 surgery, for which from the time of consult, people shouldn't wait more than six months.

Mr. Ron McKinnon: Is it just going to be genital surgery, or is there going to be other surgery, such as—?

Ms. Lorraine Grieves: Part of the announcement last November by our Minister of Health was also a scale-up around upper body surgery. We had only two health authorities offering chest and breast surgeries, and we have now, in the last year, moved to having those surgeries offered in every health region and to having 15 surgeons offer that care now; this number is up from five about a year ago.

Mr. Ron McKinnon: How will this affect the cost to people having the surgery? They won't have to travel as far, perhaps. Will it bring it into a more reasonable financial range for more people?

Ms. Lorraine Grieves: I think there will be very few costs out of pocket in the new model in our province. I think what we'll see is improved ability to return to work and less down time for people. The surgeons are quite confident that complication rates will go down because the travel will be limited and patients will have access to their surgeon much closer to home for appropriate follow-up and aftercare. We will see people be able to get back into the workforce and back to their lives much more quickly.

Mr. Ron McKinnon: I've heard testimony that some trans people don't seek reassignment surgery. Is that because they don't want it, because they can't get it, or because it's too expensive generally or takes too long?

Ms. Lorraine Grieves: I'm not a trans person, so I can't comment on anyone's individual reasons, but these are complex surgeries, especially the masculinizing genital surgeries. There is quite a high complication rate at the best of times. I think it would depend on what really matters for that person concerning their gender affirmation goals and what their care plan.... It's about building a care plan that works for them. It's a very unique choice for each individual, and—

Mr. Ron McKinnon: Would having a facility closer to home make it arguably the case that more of the people who don't get the surgery now might get it?

Ms. Lorraine Grieves: I think some people who would have faced a lot barriers to travelling to Montreal may now be able to access surgeries, though people have to be fairly stable in their lives, and able to weather the recovery period, in order to access the surgery. We may see an increase.

Mr. Ron McKinnon: If I can have my four seconds left for a quick change of pace.... With the gender markers—male, female and X—is X an acceptable addition? Is that enough? You also spoke about removing gender markers entirely. Is that the preferred way to go?

Ms. Lorraine Grieves: I'm not an expert on this topic, but I know there are very few people who actually go by X as their gender marker. I've heard from many folks in the community that they would rather see a range of options, or the removal altogether. It's a step in the right direction. I think we're encouraged by that.

Mr. Quinn Bennett: As I believe Washington mentioned earlier, if you have an X on your ID, yet all the systems and services you're trying to access with that ID do not accept it, it does create further complications around accessing those systems and services.

Ms. Sarah Chown: At YouthCO, as an employer, we've worked really hard to reduce the number of times we've been collecting that information. We've actually found that we don't need to collect it for most of the work we do as an employer, although my experience as an employee in other places is that it has been a key part of information collected. I think reducing that and providing more options for folks is a very actionable thing the federal government can do as an employer, as well.

● (1655)

The Chair: Thanks very much.

Now we go to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I hope this question doesn't offend anybody. I'm going to ask Jack, because I think you're going to be the most resilient on this.

If, hypothetically, I wanted a boob job—breast surgery—I think I would have to pay for it, because it's cosmetic. If a trans man wants to have a breast implant, is that covered or not?

Jack Woodman: It depends on what province you live in.

Ms. Marilyn Gladu: Some do, and some don't.

Jack Woodman: For implants, yes. It's a very complex issue. For example, if you were a cisgender woman who had breast cancer, and you wanted reconstructive surgery—you didn't just want the mastectomy, but implants to have reconstruction—that would be covered by your insurance plan. In some provinces, breast construction for trans women is covered, and in other provinces, it is not.

Ms. Marilyn Gladu: Okay, good.

The next question is about stigma. We know there's a lot of stigma that keeps people from seeking medical help, especially in the trans population. We asked an interesting question at a previous meeting. “How do you advertise there's a trans-educated, or trans-specific, service, without making it fearful for them to go, because it's advertised, and people might pick on them?” Is there a specific online way that would be better, or an idea about the best way to present there?

Ms. Lorraine Grieves: This is where we're really excited about training health care providers all over the place to be really competent in providing this care, so those who don't want to go to a specialized service that says “trans” on it can just show up and have a conversation with their doctor, or perhaps a counsellor in their community. That's work we're doing in B.C., through what we're calling an informed consent model for services that people should be able to get. In general, they will be able to show up and have at least a first conversation with their GP, or their primary care provider or team.

Of course, specialized services will always be needed for some people, but not for all, so we're working in what we call a tiered service model framework. I think working from the base of a tiered model, making sure general services are safe and comfortable, really alleviates that. Also, for rural folks, or people who do face barriers to showing up, some are really critical online supports and services. I think it's a good domain for people to get support.

Ms. Marilyn Gladu: What kind of training is that and how long does it take? Who's offering it? Is it for doctors, nurses or triage people?

Ms. Lorraine Grieves: We're rolling forward a tiered training model in B.C. Starting from the basics, our shortest is a half-hour online module. It's to whet one's appetite around what we call the trans basics. Sometimes, we'll combine an online module with a live teaching opportunity. We're developing learner pathways for the different parts of the system of care where the training is needed. It's from brief to much longer for advanced practice professionals. It really depends on the setting, and what the intention of the training is.

Ms. Marilyn Gladu: In terms of urban and rural differences in trans health, other than the fact that a lot of medical services aren't available to anybody who's more rural and remote, are there specific actions you would recommend we take, to try to address LGBTQ health in rural areas?

Mr. Quinn Bennett: I just have one thing to mention around that. I think that in communities that are lacking the knowledge or the awareness.... I'm thinking about Doug's comment earlier about his friend who is the teacher who said, "Please don't talk about this."

In situations like that, I think we really try to identify a community champion. This might be an older trans person who lives in the community. This might actually be a teacher. It might be a supportive mum. It's someone in the community who can act as a bit of a resource, a go-to and a support. Specifically, we're really concerned about youth who are isolated and completely detached from resources that could support their journey ahead. I think that looking for folks in the community who can be those support resources is really important.

Ms. Marilyn Gladu: Sort of like an ambassador.

Ms. Lorraine Grieves: Just to add to that, we're having a big piece of work go forward around virtual health options, and we're piloting virtual care where people can be seen right from their home through a private, secure platform, through the provincial health authority. We think that will go a long way towards rural access, as long as people have the Internet. There are many communities in B. C. that might not have that either. There's lots to do there.

● (1700)

Ms. Marilyn Gladu: Well, it's the federal government's job to put broadband Internet across the country, so we will do that.

Ms. Lorraine Grieves: Okay, great. There's a recommendation.

Ms. Marilyn Gladu: That's the end of my questions. Thank you so much for your testimony.

The Chair: Now we go to Ms. Damoff.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thank you all for your presentations. You are outstanding.

Can we stop calling it "conversion therapy"? This is a comment, not a question. Therapy, to me, implies that it's a good thing. Poor Sarah has heard me moaning about that a lot, and you're not the only witnesses who have said it. I don't have a better term, but surely to goodness, if we're going to change the conversation around it we can stop calling it a therapy.

Lorraine, you've talked a lot about training. We've heard other witnesses talk about that as well. Do you see a role for the Public Health Agency of Canada to provide training to health care workers?

Ms. Lorraine Grieves: I think so. In our brief, we recommended that there's work to be done with the network of trainers and educators across the country. There are many groups doing this work but without very much dedicated funding. I think any strategy needs to be informed by the strengths and the resources that are already there. I would suggest that PHAC work with the existing network to really figure out how to scale up.

Ms. Pam Damoff: One of the things I've noticed is that a lot of the stuff we hear during this study has been provincial—education and sex ed curriculum in the schools, and the delivery of health care. I'm trying to focus on what the federal government can actually do. I would think that it could provide some leadership by providing that training so that all of them—health care—do end up getting trained through whatever body it might be.

Another one is access to grants. I was talking to an organization that said they had women and gender equity now but that there were limited places where they could apply. You can apply through the Department of Indigenous Services, but there are very limited grants specific to LGBTQ and—in particular—trans organizations.

Ms. Lorraine Grieves: That's very true. Prior to Trans Care BC existing, I had six years of federal funding to do this work, but it was a bit cloak-and-dagger. We used the substance use prevention stream to apply for money to work on moving toward GSAs and community action related to LGBTQ2 prevention. You'll find that many groups that do this work have had to kind of find ways to use a disease stream or another stream of funding in order to focus on the population. We could use dollars just focused on the populations we're talking about, for broad health work.

Ms. Pam Damoff: Okay.

Did you want to add, something?

Ms. Sarah Chown: Definitely, we need to see those funding dollars.

Ms. Pam Damoff: Well, it makes it difficult if other organizations.... We've done a good job of increasing funding with certain different groups. It's never enough, but....

Another one is representation in clinical trials. I was speaking to an organization last night where women of African history are not represented in clinical trials for breast cancer. Is there adequate representation? I'm thinking in particular of trans individuals who are dealing with hormones, and whose physiology—if that's the right word—is different than maybe Robert's or mine would be. Is there adequate representation in clinical trials?

Jack, over to you.

Jack Woodman: No, there is not adequate representation. We're doing some work at my organization now around applying a sex and gender lens across all research for any research study that occurs. Historically, that has meant that it needed to include women. Now we're really looking at gender in a much broader way, but that's very new.

The other thing is just accessing sufficient numbers in the studies of trans populations. I will re-emphasize the piece around the ethical guidelines for conducting research in these populations, because there are a lot of things that need to be considered when we're including those folks.

Yes, absolutely, we need more representation, and we also need to encourage researchers through funding to include this within the sex and gender lens and also to apply those ethical guidelines.

Ms. Pam Damoff: Okay. I only have a few seconds left, and this is an easy question. Witnesses last week were saying that when they come to committee, it would be helpful to know pronouns. I prefer "she and her". It wouldn't cost the government anything to add pronouns to witnesses and to MPs when you're addressing us. Do you folks think that would be a good idea?

Ms. Sarah Chown: I think that speaks to what I was saying before about the federal government's role in normalizing these conversations. If the federal government had names and pronouns every time, that would lead a lot more people to learn about that and to start doing that as well.

● (1705)

Ms. Pam Damoff: We could easily even just add it to these sheets that are handed around.

Thank you.

The Chair: Now for our final question, we'll go to Mr. Davies.

Mr. Don Davies: "He, him...."

Jack, what percentage, or how many Canadians are going to other countries for surgery? I just wonder if there's a particular place where they tend to go for surgery.

Jack Woodman: I'm not sure. I would have to get back to you on the percentage of Canadians who are going—

Mr. Don Davies: The number of people, just to get an idea of the scope.

Jack Woodman: You know, what I can say is that in Ontario, over a nine-year period, there were $10 million in out-of-country costs. I'm vague on that data, but I can follow with it. The countries are the U.S. predominantly, but there are folks who do have surgeries in places like Thailand.

Mr. Don Davies: For any of you, I was just wondering whether there are any countries or societies that are doing it better than we are. This would be where members of gender-diverse or sexual minorities are living with better security, better safety, better health care and better everything. Is there any place that you could point us to?

Ms. Lorraine Grieves: No.

Jack Woodman: I don't have a lot to say on that. I think there are cultures within the world that are doing it better, where gender is just more fluid and more accepted. I can't really say that this always translates into equitable employment status or that sort of thing, no.

Mr. Don Davies: It's all relative.

Yes.

Ms. Lorraine Grieves: Could I make a comment about the question you asked about out-of-country care?

Mr. Don Davies: Yes.

Ms. Lorraine Grieves: I wanted to mention that hormone therapy doesn't work the same for trans masculine people as it does for trans feminine people. In B.C. we've been seeing trans women suggesting things like facial feminization surgery and facial hair removal. There are other interventions that would be required that would increase safety and well-being. For those, British Columbians aren't funded. We do see, unfortunately, some trans women quite urgently needing that care and travelling to places like Thailand for facial feminization surgery and then coming back with very serious complications.

It's a really important area to look at.

Testosterone really makes a lot of changes for a trans man—bulking up, facial changes, hair growth—whereas for trans women, estrogen doesn't work because you can't override the testosterone in the same way. Often more surgical intervention is required for trans women.

Mr. Don Davies: We've heard some extremely disappointing, if not shocking, information about the lack of education in our medical faculties, and how little doctors are.... I'm even thinking of colleges for teachers. Have any of you been invited to speak to faculties of medicine or teachers' colleges to help begin that process of educating?

I'm seeing a lot of nodding.

Washington Silk: Yes, I partnered with the University of Waterloo to do a trans wellness conference in Waterloo, which was attended by doctors. We're also working with our local hospitals and mental health professionals to improve care. On this end, however, it often means we overextend ourselves to make sure that we deliver free, accessible programming and that we're there when the doctors ask. Otherwise, they're not going to be receptive to the information. We get a lot of feedback from our young people accessing psychiatric and hospital care that it is not adequate. We really go out of our way to say "hear us". People often do not come to us.

Mr. Don Davies: Thank you.

The Chair: I just want to say to the panel, you are incredible. I think everybody feels that. You're helping us understand, and we don't understand. It's a whole new vocabulary for me. I'm glad Don Davies said he's learning, because I'm sure learning.

Mr. ... Jack said—

Some hon. members: No.

The Chair: Jack said—

● (1710)

Ms. Marilyn Gladu: Go back to school.

The Chair: I'm learning.

Jack said it will be a future where notions of presumed gender and expected behaviours and identities based on sex will be old and obsolete. I hope you're right, but we have a long way to go.

This is our sixth meeting and the witnesses are all so articulate and knowledgeable. You know your issue, your subject, your challenges and your hurdles.

On behalf of the committee, I want to say thanks very, very much for your testimony because it is incredible. I wish that those seats were filled with Canadians. I just wish all Canadians could sit in on all these meetings we've had because we've learned a lot. I know I've learned a lot and it's been incredible.

Thanks very much on behalf of the committee.

We are going to suspend for a couple of minutes and then we're going to resume.

[*Proceedings continue in camera*]