ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room, 90-130 Swanston Street, Melbourne, Victoria

On Wednesday, 17 July 2019 at 10.00am
(Day 12)

Before: Ms Penny Armytage (Chair)

Professor Allan Fels AO

Dr Alex Cockram

Professor Bernadette McSherry

Counsel Assisting:

Ms Lisa Nichols QC Ms Georgina Coghlan Ms Fiona Batten MS NICHOLS: Good morning, Commissioners. The Royal Commission's terms of reference directs this Commission to inquire specifically into how to improve the mental health of those at greatest risk of experiencing poor mental health outcomes.

Today we will focus on mental health outcomes in the LGBTQI community. The term LGBTIQ, or QI, is an inclusive abbreviation to encompass a range of diverse sexualities, genders and sex characteristics. It stands, of course, for lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning. The term has evolved itself over time and is viewed and experienced differently by different members of the community. Other terms of course are also used.

 There is great diversity of identities and experiences within and between LGBTQI communities, influenced by age, ethnicity, geographical factors, location, disability, migration experience, socio-economic experience and so on.

LGBTQI people are part of all other population groups, while also forming a specific marginalised population group.

Although most LGBTQI Australians live happy, healthy lives, a disproportionate number experience worse health outcomes than their non-LGBTQI peers in a range of areas, specifically mental health and suicidality.

The disproportionately poor outcomes are found in all age groups amongst LGBTQI people. The mental health of LGBTQI people is amongst the poorest in Australia. LGBTQI people have the highest rate of suicidality among any population in Australia.

 The evidence, as you will hear, is that the elevated risk of mental ill-health and suicidality is not due to sexuality, sex, gender identity in and of themselves, but rather due to discrimination and exclusion as key determinants of mental health. This is sometimes referred to as "minority stress".

There are other contributors to mental ill-health too. For example, lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with family or no family on whom they can rely for

serious problems. Figures are likely to be even higher for trans people. There's a long list of compounding factors like this one.

Trans and gender diverse young people are a highly vulnerable population with very poor mental health outcomes. A recent study of the mental health of trans young people aged 14-25 living in Australia found that 75 per cent had been diagnosed with depression; 80 per cent had reported self-harming; and 45 per cent have attempted suicide.

 These outcomes bespeak insidious discrimination and disadvantage that's completely at odds with the values expressed in this Commission's terms of reference. The fact that these matters are being considered here is one opportunity for Victorians to do a whole lot better than that.

The mental health system itself must, of course, be a system for all. It must provide the same quality and level of care to all Victorians.

In today and tomorrow's hearings we will recognise that communities of place, culture and identity must feel safe to seek help and be confident that their needs will be understood and met.

Tomorrow, we'll be focusing on mental health outcomes in culturally and linguistically diverse communities and on their engagement with the mental health system.

Ms Coughlan will say more about that tomorrow morning.

For the purpose of these hearings over two days there will be a focus on these particular broad groups. We appreciate that there is a multiplicity of issues and also a number of sub-populations that we do not have the opportunity to explicitly address in this round of oral hearings.

The fact that we will be focussing on these populations and these issues should not be taken as a statement that these are the only issues or the only populations with whom the mental health system must grapple and serve, but we hope that by exposing some of these issues we can inform our thinking more broadly.

Turning to the witnesses to be called today. First you will hear from Ro Allen, who is Victoria's first Gender and Sexuality Commissioner. Commissioner Allen advocates within government for the rights of LGBTQI Victorians. They will talk about the impact of stigma, abuse and prejudice on the mental health of LGBTQI people and the need for mental health services to provide inclusive care.

Dr Ruth McNair will talk about her role as a GP at the Northside Clinic which has a particular focus on providing primary care and allied mental health services to the LGBTQI communities in Melbourne's north. She will speak about the most vulnerable members of the community, barriers to accessing mental health services, and the systematic changes that could be implemented to reduce them

Associate Professor Michelle Telfer is the Head of the Department of Adolescent Medicine at the Royal Children's Hospital. The Royal Children's Hospital has the leading centre for medical and mental health care for trans and gender diverse young people in Australia. She will address why it is that trans and gender diverse young people experience poorer mental health outcomes compared to the general population and compared to other parts of the LGBTQI community. She will give evidence about the gender service provided at the Royal Children's Hospital.

Katie Larsen is the General Manager, Diversity, Inclusion and Participation at Mind Australia. She will give evidence about Mind and the Mind Equality Centre, a specialist counselling and support service operated for LGBTQI people. She will talk about Rainbow Tick accreditation which is a quality improvement framework to assist health services to move from being LGBTQI friendly to being inclusive.

Finally, a consumer witness will be called; they will talk about their experiences as a trans masculine person trying to access appropriate mental health services and how challenging this was. They will be giving evidence using a pseudonym and their evidence will be the subject of a non-publication order which prohibits identifying information from being published.

I will call the first witness now, Commissioner Ro Allen.

<RO ALLEN, sworn and examined:</pre>

[10.08am]

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MS NICHOLS: Ο. Commissioner Allen, are you Victoria's Commissioner For Gender and Sexuality?

That's correct.

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- Q. Are you the first such Commissioner in Victoria?
- That's absolutely correct. Α.

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And in Australia? Ο.

but the same community.

In Australia as well, yes. Before I start, can I just acknowledge that I give my evidence today on the land of the Wurundjeri people and I pay respects to their Elders past and present and all Aboriginal people, and also just take a moment to remember everyone that we have lost through suicide, and particularly LGBTQI people today and it's in their honour that I give evidence. Thank you.

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Thank you, Commissioner Allen. Have you, with the assistance of the Victorian Government Solicitor, prepared a statement which addresses the questions the Royal Commission has asked of you?

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I tender the statement. [WIT.0003.0007.1001] Can I just ask you a question about language before we commence. Is it the case that language used to describe lesbian, gay, bisexual, trans, gender diverse, intersex and queer people, in different parts of those communities, has changed over time and can differ between people and across cultures? Absolutely. I think every time we look, the alphabet gets a bit longer, language is evolving. In America, they just use LGBT; in Australia we use I for intersex community. Recently in government we've just added the Q. Sometimes it can be Q and I. There's different variations,

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- So today, if we use one of those variations we'll both be speaking about the same broad community, if that's alright?
- Some of the data though does just actually look 42 at different parts of that community. So, if my submission 43 refers to a particular part of the alphabet, it's because 44 that's the bit that's been researched. 45

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Indeed, and we'll go through that when we look at Q.

particular parts of the data.

In July 2015, you were appointed Victoria's first Commissioner for Gender and Sexuality. What are the core functions of your role and how do you advocate within government for the LGBTQI community?

A. The core role is really to make Victoria a safer place for lesbian, gay, bisexual, trans, gender diverse and intersex community. I do that within government, I sit within the Department of Premier and Cabinet which gives me great access to all levels of government. I do things like train LGBTQI 101, I've recently done that with the judicial system, magistrates and judges across Victoria to make sure that when our community is before any judge or magistrate in Victoria that there's a clear understanding of our communities and our families.

So, anything that can provide education, reduce discrimination and stigma, that can be in the corporate world around how to employ more trans and gender diverse people who are under-employed. It's in sporting facilities, so I get to go out of government and work right across with the AFL and others around sport because there's discrimination in sporting areas as well, and we know that physical health has implications on our mental health. It's a very broad portfolio and I get to work right across many stakeholders in that.

Q. How does your role consider and respond to issues relating to the mental health of the LGBTQI community?

A. Well, I think my fundamental role is to reduce the stigma and educate people, and really, as you said in your introduction, it is not our gender identity, our sexuality or our intersex variation that is the cause of our mental health, it is actually the discrimination that we experience, the isolation, the family rejection that is the cause of that. So, that's my major focus, I'd say. Everything I do is for the betterment of the mental health of the LGBTQI community.

- Q. Can I ask you about the differences between the mental health outcomes of the LGBTQI community and the general population?
- A. Yeah. We unfortunately, as you said, many of us are doing very, very well, but unfortunately some of us are parts of other high risk groups as well. We know that homelessness is a key factor; many trans and gender diverse

folk are homeless due to low unemployment. Certainly, gay men around poverty, poverty's another issue. Many gay men didn't believe they were going to be alive as long as they were so they didn't plan a future in that, so poverty is one of the indicators, and of course we're represented there; as well as homelessness; we're also over-represented in family violence, so we have family violence in our communities, but for our community that includes the violence that's perpetrated upon us by our family members, and so, we know that's another causal or risk factor for mental health.

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I think it's the ongoing minority stress, and you mentioned that as well: that every day knowing that, any time you step out of the door, or even within your own family, you can experience physical or verbal assault or abuse in any way or shape, and that is an enormous level of anxiety that we can carry as community.

- Q. Did the Australian Bureau of Statistics in its 2007 national survey of mental health and wellbeing find these things: that 41.4 per cent of gay, lesbian and bisexual people over the age of 16 had reported symptoms that met the criteria for a mental disorder in the previous 12 months, compared to 19.6 per cent of heterosexual people of that age grouping?
- A. That's absolutely right.

- Q. Did the survey also put that for anxiety, 35 per cent of gay, lesbian, bisexual respondents reported an anxiety disorder compared with 14.1 per cent of their heterosexual counterparts?
- A. That's absolutely right.

 Q. Did the same study report that for effective disorders, 19.2 per cent of gay, lesbian and bisexual respondents reported an effective disorder compared with 6 per cent of their heterosexual counterparts?

A. That's correct.

- Q. Does research conducted by the national LGBTI Health Alliance in 2016 also show that, compared with the general population, LGBTQI people of 16 years of age and over are nearly three times more likely to be diagnosed with depression in their lifetime?
- A. Yes, that's right.

- Did that also show that trans and gender diverse 1 Ο. 2 people, specifically aged over 18, are nearly five times more likely to be diagnosed with depression in their 3 4 lifetime?
 - Yeah, it's a really poor picture. Α.

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- Do you see outworkings of these kinds of statistics in your day-to-day work and life?
- Yeah, absolutely. I think that the constant living with the fear of being discriminated against - I mean, my own personal experience of physical harm and violence, it has an accumulative effect - as you've said, minority distress - and we don't always get included in services and mental health services.

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I think it's important to remember that in mental health services, it's only in the 70s did homosexuality come off the DSM as a mental disorder, you know, and so there's that stigma that's attached to that. last year that being trans or gender diverse came off the DSM as a mental disorder.

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- What are the implications of that?
- Well, it's the belief, the self-shame that people You know, we don't wake up in the cot hating ourselves, it comes from somewhere, and it's that stigma about how we are labelled and identified, whether it's through the media, whether it's through the recent postal survey which was a tsunami of attacks on our mental health, an actual campaign against our mental health. It comes from those places and we carry that. And obviously LGBTQI people at different levels carry different levels of that depending on their life experience. But it's also the perception of how you may be experienced and not just the reality of that every day.

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- I'll ask you more about that in a moment. Can I ask you first, do LGBTQI people have higher rates of suicidality?
- Yes, they do, and I think we have very, very bad data collection around this. I can remember going to funerals of young LGBTI people and families didn't know that they were queer; it certainly wasn't recorded, and for the shame and the stigma related to that. Even if they did know that their son or daughter or child had actually committed suicide because of their gender identity not being recognised or supported in the family, or sexuality, it

wasn't recorded. So, I would say that even though we know that statistically the suicide of our community is so high, I would say it's an under-reporting of that as well.

Also, one of the very high risk periods we know for mental health in our community is just before you come out. So, it may be that family generally don't know that somebody is dealing and grappling with those issues, so very unreported in relation to data as well.

- Q. Can you elaborate on the very high risk period just before people come out?
- A. Yeah, I can certainly talk about my own experience and others. Before you come out is obviously a very high risk period because you don't really know it's the fear of family exclusion, potentially if you're trans coming out, it's losing your job, your family, your friends; you could be losing your church, your sports club, all of the connectors and protective factors we have that protect us around suicide.

I always say that, you know, it's how the first person responds when you come out can set you up in your mental health for the rest of your life, because everybody in the room that's come out and everybody, LGBTI in Australia will remember the first time they came out to someone and they'll remember exactly what that person said, and I think they're really high protective factors for folks.

It may be the first time that somebody comes out about their gender identity or sexuality is actually within the health service, and so, that's so critical that the very first response they get is a positive one.

- Q. You mean, there may be a conversation with a GP, for example?
- A. Oh, absolutely. It's so important that every GP has the basic LGBTQI 101 and says and can refer to appropriate places and not to conversion practices, which has been an historic thing that has been obviously very, very detrimental to our community.

Q. We'll come to that one. Are there particular subgroups that have even worse rates of suicidality, like Aboriginal and Torres Strait Islander young people?

A. Yep. This is a very dangerous question because there are so many groups, I may forget. But, of course, all of

the other intersectionalities within our community and the combined discrimination and racism for First Nations people that may or may not be accepted within their own communities.

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Within the migrant and new arrival community and refugee community, coming out can still be a very dangerous thing. You can be sent home for conversion practices to the country that you've come from. If you are a student, we have a number of international students who come, feel safer in Australia. Many of the countries they come from, such as Malaysia or other countries, it's actually illegal They find some freedom here to be gay in those countries. in Victoria, the equality state, and so it's very difficult culturally for them on needing to return, and it's a high risk of suicide in those periods leading up to when they're being forced to return home.

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Of course, rural and regional folk, the list goes on in relation to all the different sub-groups. So, rural and regional folk, isolation for service providers and the risk of confidentiality in local communities and not feeling like you can access services because of that.

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People with disabilities who are LGBTI, may have neurodiversity issues as well. For many in the disability sector and world, they aren't even considered being heterosexuality or having any sexuality, let alone anyone with a disability being considered as homosexual or bisexual.

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Bisexual people have a higher rate of stigma and discrimination than heterosexual people. Bisexual people can be, not always, but can be discriminated not only from heterosexual cisgender community, but also within the gay and lesbian community can be very cruel as well.

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I mentioned cisgender there, I might take you to my glossary.

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- That was useful, can you? Q.
- As I said, language is ever evolving. Cisgender just refers to somebody who's been allocated female at birth, grows up and is a woman, or allocated male at birth and grows up and is a man. So, just as we have heterosexual and homosexual, we have transgender, gender diverse and cisgender, so that's another factor.

reference to the notion of vigilance?
A. Yeah.

Q. Can you say something more about that?

differences in mental health outcomes.

mentioned minority stress.

Can I talk to you about the reasons for the

We have both

In that context is there often

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don't fit within what the community and society understands as gender norms, just going on public transport, you may need to be constantly vigilant. I live with that myself, I'm constantly vigilant about where I am and what I'm doing and always scouring for safety in relation to, just travelling through the world.

Certainly for trans and gender diverse folk, if you

It's not uncommon, it's not uncommon to just have abuse yelled at you as a LGBTQI person from a passing car. In my case, many others, you never know whether that's going to escalate into anything potentially violent.

Then there's other things that you just live with around access and inclusion in services. The Royal Commission is absolutely fabulous today, you arrived, you were incredibly welcomed, there was very friendly security, very friendly welcoming party, there's crayons and colouring books for kids, tea and coffee room, everything you can imagine. But when I asked for the bathroom, I was directed to male and female bathroom. Now, for me who is gender non-conforming or gender diverse, instantly it raises anxiety. To be honest, I came early because of that, I often turn up early to places.

I also knew that everybody in the gallery, or some people in the gallery may be LGBTQI and it may be another issue for them, so I was able to make sure that everybody here at the Royal Commission, when they were asked, they send a little WhatsApp message around to all the staff that they wouldn't just direct people and assume that they were male or female, that they would make it accessible and I've got the lights on on the third level.

It's all of those things that you live with every day. The fact that I know every gender neutral safe toilet in Metropolitan Melbourne and most of rural Victoria is alarming, but that's not an individual thing, that's quite a common experience. In fact, there are apps for safe

toilets.

Again, you talk about the stigma, I hope that's not the media grab that comes today. But, you know, "Commissioner comes early to Royal Commission to scope toilets."

- Q. I think you might have just made it into the media grab anyway.
- A. Yeah, I've just done that. That's a chance to talk about the media, no reflection on the fabulous media that are here today, but it's how our LGBTQI community is stigmatised around that.

- Q. Can you say a bit more about negative stereotyping as a risk factor for the development of poor mental health outcomes?
- A. Absolutely. I remember as a youth worker speaking to young people, and the only kind of media or connection to community they would often see, particularly in rural and remote communities, was on television, and they'd get this picture of Mardi Gras, you know, and they'd see a half-naked drag queen, and they think, well, that's not me. But they don't see the 100,000 people that are marching for their rights and their freedoms.

That's how we are a resilient community. We experience so much discrimination, we come together to celebrate ourselves and identity because the other parts of community haven't always celebrated us, and yet what we get fed back to us are particular images and frantic things about toilets and trans people in toilets and all this other sort of stuff.

The messaging we get back all the time is that you're perverts, you're deviants, you're paedophiles, all of these misconceptions. And so, as I said, you don't wake up in the cot hating yourself, all this stuff is accumulative and builds to minority stress, and how we develop understandings.

It also stops us from accessing mental health services because of the sense of not being worthy. The number of Elders in my community that have said, no, no, no, Commissioner just make it better for young people, we've had our time, you know. It's a lovely gesture, but also I know it comes from a place of not feeling worth and

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- Q. Can I ask you about violence, and does research show that up to 80 per cent of same sex attracted and gender questioning young Australians have experienced assaulting behaviour in public?
- 8 behaviour9 A. Yes.

- Q. And 20 per cent of that same group have experienced explicit threats; 18 per cent have experienced physical abuse, and 26 per cent have experienced other forms of homophobia?
- A. That's absolutely correct, and how can that not affect our mental health? Yeah.

- Q. For trans and gender diverse people, are the rates of the experience of violence, whether verbal or physical, particularly high?
- A. Yes, they are. Yeah, absolutely.

- Q. Does data show that about 30 per cent of that group have been threatened with violence?
 - A. Absolutely, and experienced it, yes.

- Q. What about the question of loss of contact with family? Is the data that rejection by family is higher in LGBTI people than the general population?
- A. Absolutely, and even the fear of losing family contact is really high, but the reality is that many LGBTI people, at any age, can be rejected by their family. Particularly young people coming out can be rejected, but also older people who may come out later in life can be rejected by their children and be particularly vulnerable, if particularly as an elder they are reliant on their children.

 We had this story not that long ago of an elder put in aged care who had the power - in the kid's power. They put them in aged care as the gender they were assigned at birth, not the gender that they'd be living for the last 40 years of their life. So, family can be, you know, the perpetrators of violence against our community as much as the broader community. So, you can get it from all areas.

I think it's also important to remember that, if you

are from a multicultural community or an Aboriginal community, you usually have your family around you and you all travel through and experience racism together. Often if you're an LGBTI person, you may be the only LGBTI person in your family, and so, that can also be an isolating experience as well. So, families can be protective, but they can also be a cause root of our mental health issues.

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Q. I was just about to ask you that. It may sound an obvious proposition, but is family connectedness a strong protective factor against poor mental health outcomes?

A. Oh, absolutely. You know, I was very lucky when I came out to my family, I was very, very supported. I have been supported by family right through this role; my mother campaigning enormously through the postal survey, you know, in her nursing home. She'd done the numbers, she said, "We've got it Ro" based on the nursing home, we're alright. Reminding everyone except the people who I think are going to vote "no": thanks, mum.

You know, those connections that people have with family are so critically important, but there are so, so many people that don't have my experience of family connection. And we create our own families, we create our own families of choice. And, of course, our families not being recognised has been an enormous barrier; the families of choice that we create has only recently been accepted fully in Australia. They all - it all is stigma and discrimination.

- Q. Can I ask you to say a little bit more about the role of language and public discourse. You mentioned the postal survey a couple of times. Is there evidence that there was an increase in hate speech and conduct surrounding the postal survey which, for clarity, was the ABS postal survey to determine whether legislation should be changed to permit same-sex couples to marry?
- A. Yes. We are now a little bit out of that time-wise, we can actually start to look at some of the data that we knew was happening to our communities.

 We saw an incredible increase in hate speech on social media and in the general community during that period. People will say, look back at history and say it was all sorts of things, but for our community it was just a tsunami of attack on our mental health.

Switchboard, which is an LGBTQI phone counselling service that I talk about in my evidence, saw an incredible increase during the postal survey period. In fact, we didn't have enough volunteers. Switchboard is run by LGBTI volunteers, so it's peer-led. You will ring up and get an LGBTQI person. We didn't have enough people during the postal survey to be able to equip the phones. We ran extra sessions, emergency sessions, calling up people off the bench that hadn't been counsellors for 20 years. the woman who started Switchboard came back after 20 years to go through a training session and get back on the phone so that we could try and meet the need. We know we didn't answer every call.

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- Q. Why do people call into Switchboard typically?

 A. Switchboard provides peer support, so really if they're struggling for their mental health, or anything around being LGBTI, life in general, isolated, needing support. A lot of calls come in just before somebody comes out and Switchboard can make referrals, but they're really calling to talk to someone that's like themselves, to hear someone that understands the journey that they're on, and that's why peer support programs for our mental health run by LGBTI organisations governed and run by LGBTI people are so important in the system.
- Q. Was there preliminary research conducted by the Australia Institute and by the National LGBTI Health Alliance based on a study of close to 10,000 participants following the postal survey which showed that about 80 per cent of LGBTQI people and almost 60 per cent of allies and I'll ask you about what that means in a moment said they found the marriage equality debate considerably or extremely stressful?
- A. Absolutely right. I was married three months ago, happiest day of my life. I would give it up in a heartbeat if it meant I could undo the three months of torture and trauma really there was on our community.

 People who have been out for a long time, people who are employed, well to do, feel quite secure in their self and their identity, whose family supports them, talk to me about all sorts of triggers that that period gave, and they were the people that were doing very well. So, it doesn't take much to think about the people in our community who are already vulnerable.

Many in our community completely switched off their

social media during - and I recommended that, but they switched off their support. So, as well as switching off seeing all the negative things, during that period they also switched off from being able to get connections and support.

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> Every day you could open the newspaper or turn on the radio, or anything, and hear that you're going to hell. You know, it was a regular event, letter to the editor, the slippery slope argument, all the things that were coming to us.

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I remember for me personally that my partner, now wife, and I thought we'd protect our child for the next three months. That was ridiculously naive because it was everywhere. When you're, as I was, standing in front of a group of people delivering LGBTI training and talking about how important it was, behind me out the window was a plane writing an ginormous "no" in the air. Everybody could see that, there was an awkward uncomfortableness and eventually I turned around.

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But not only did that "no" affect me in a visceral way, I knew that the kids in my kid's school were watching that, all the Rainbow kids in schools all over Melbourne were seeing that, every LGBTI person that was vulnerable was seeing that "no" in the air. You know, you couldn't avoid that, and it attacked my mental health, and I know it affected so many people.

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For me, I have a very, very supportive work environment. My boss is the Minister For Mental Health. He was very clear that I was going to get support and counselling every two weeks during the postal survey. would not have looked good for the Commissioner for Gender and Sexuality to fall over. But not everybody can afford to do that or has the work environment to be able to do I'm very proud of the Victorian Government that made rooms available for all the staff across Victoria to watch the results of the postal survey.

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I mean, the fact that I know where I was and that every LGBTI person in Victoria can tell you exactly where they were at the time that the results were delivered, is a real testimony to the impact that it's had on our lives.

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As well, we're now seeing, 12 months on in the

research, that there's another blip in our mental health at the 12-month anniversary: you know, people are thinking we should be still excited, we should all be off getting married, how wonderful, but we saw another increase in phone calls and calls on services at Switchboard in that 12-month period. So, I believe it's going to have a generational impact on our community, and may we never have another postal survey that a majority in Australia makes a decision about a minority of any shape or form.

Q. Can I just return to that same survey: did it also find that LGBTQI respondents said that experiences of verbal and physical assaults in the three months following the announcement of the postal vote more than doubled compared with the six months prior to the announcement?

A. Yeah, absolutely. It was an authorising environment for hate speech, and I think, you know, hate speech runs at a level in our community, but it just gave the green light. Again, it's a minority group of people that are so vicious that they would do that and yell out of cars and physically attack people, but it's certainly allowed them to do that.

We saw an increase of posters and campaigns, in every language, campaigning, talking about how deviant we were, it was in every language in letterboxes all over Victoria; posters that were absolutely horrific that showed us in terrible light. We see them occasionally, but there was certainly an increase during that period which was intense.

- Q. Is work going on to conclude that research or to take it further?
- A. Yes, there is, yep. And I'm actively involved in a new coalition of universities and the Victorian Police and others in looking at hate speech broadly.

Q. In relation to that survey which was described as preliminary, will the results or the further work likely to be concluded within the lifetime of this Commission?

A. I would need to take that on notice.

Q. On notice, yes.

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A. But I would hope so, because I think it's a really clear picture of the impact that that sort of process can have on mental health, so even the preliminary findings are pretty compelling, I believe.

Q. Alright, and if you do complete that work, I'm sure

you'll provide it to us and we'll ask you for it.
A. I will.

Q. Can I turn now to the question of examples of resilience and self-care in LGBTQI communities. Can you speak to us about some powerful examples of resilience?

A. I think generally we need to classify our community as one of incredible resilience, and we've done that in a number of ways. I've talked about the celebrations, festivals and events, Mardi Gras, pride marches. We do that as a sign of resilience and coming together as community. Broadly, the community you can just see as flamboyant festivals of fun, but they have a real intent about making sure we come together, we check in on each other.

During the 80s, through the HIV AIDs epidemic, the Victorian AIDS Council, now Thorne Harbour Health, was developed. That's a great example of resilience where our community came together to fight for our survival, but also fight the stigma that particularly gay men had that lived through the Grim Reaper campaign which was another media campaign really that has left a lifetime - people of my generation will remember the Grim Reaper and that caused enormous stigma for gay men. So, groups like that. Switchboard I've talked about, Queer Space at Drummond Street.

There are so many peer support groups that have been established by community for community that are really about resilience and support and being with each other.

Recently it again came out of the postal survey, but social media now, we have a Grateful Rainbow Facebook page which again is around making sure that we focus on resilience and strength and supporting each other, and we focus on gratitude. So, for 60 days after the postal survey leading up to Christmas, which we know is a high point time, because many of our community aren't connected to family, Christmas isn't always joyous, to post one thing that we're grateful for. That's coordinated by community for community.

Those sort of initiatives outside the structured mental health service go an enormous way to support ourselves and to remind ourselves, if the rest of the world isn't, that we are fabulous, wonderful, worth celebrating

and quite resilient.

Not all members obviously, and we've dived into some of that, have that resilience. And there's some stigma about not being resilient in our community as well.

Q. Can you say a bit more about the expression "by community, for community"?

 A. I think in government we call it co-design, but basically what it really means is, nothing about us without us; that everything, health service, mental health service, needs to be designed with us. We learnt that in the Royal Commission on family violence. The projects that are working, are working with our community.

It's certainly not saying that the only support for our community needs to be from our community, and we certainly - I wouldn't want for a minute to let mainstream mental health services off the hook at all in that. But what the services they design need to be are inclusive and culturally sensitive to LGBTI people. The only way to truly do that is to actually involve LGBTI people in the creation of those services.

Q. Yes. Can I ask you now a little bit more about access to mental health services. Is it the case that there is evidence about the non-use of crisis supports for fear of discrimination?

Yeah, absolutely. I think it's absolutely, unfortunately, on the mental health system to prove that they are actually safe. When an LGBTI person goes to any service, they may not disclose in the beginning, and what Am I safe? Can I trust they're saying is, do you see me? you? And they are incredibly unforgiving if they get a poor response in the first place; they're very unlikely to go back to that mental health service. Or even the perception, not even walking into that service, that they will be discriminated against will exclude them from early intervention and they may only go into that service when they're actually a tertiary high end need.

You have to remember that an example of a gay man I know, his experience of the mental health service was electric shock treatment in his life. He didn't have a mental health issue at all but that was purely done to him by the mental health system because he was homosexual and it was an idea that it was a disorder and he needed to be

cured as a therapy. There is no way, the earth would freeze over before this gentleman would go back into a mental health service. You could paint it with rainbows and shower it in glitter, this man's not going to go back into a mental health service. So, it's really about how do we actually make sure that people know that it is safe and that they're not going to be discriminated against in that service, yeah.

Q. Did recent research undertaken by the Lifeline Research Foundation show that over 71 per cent of LGBTI participants choose against using a crisis support service during their most recent personal or mental health crisis? A. That's absolutely right, and there's all sorts of factors that play in this. People may not want to call up an ambulance because potentially they may believe, perceived or real, that the police will be called. I know that you've heard evidence about the amount of police involvement in mental health cases.

Unfortunately, our community historically has had a very bad relationship with the Victorian Police. We're working very hard to improve that. We now have LGBTI liaison officers, we have terrific support within the Victorian Police, but again, historic beliefs and understandings about whether you will be supported and discriminated, so even to get into a mental health service if they think there will be police involvement. Their family may not call them as well because of that, particularly if it's a rainbow family and they have poor experience of the police and the system. Or just being discriminated when you arrive at a hospital or health service is so critical.

- Q. Can I ask you whether inpatient settings pose particular risks?
- A. I think they do, and I think other witnesses will give you evidence around the benefits of the Rainbow Tick. The Rainbow Tick is an accreditation that health services can do. It is so important because it takes you through a whole journey of cultural assessment, cultural change for your organisation.

Basically what we do in the health service system generally is assume that everybody who presents is cisgender and heterosexual, and it's such a barrier to our service, it's a barrier for our families. It needs to be

changed. We've learnt again from the Royal Commission Into Family Violence that we've funded a number of family violence organisations to get the Rainbow Tick and we're starting to see that improved; whether they're a lanyard on a staff person that is a rainbow or trans colours, a badge that's really important. We've recently added the black and the brown onto the rainbow to acknowledge First Peoples and people of colour.

That is so critical. If I walk into any health service and I see a rainbow, I'm instantly relaxed and I know that's a similar experience for many. It's all the way through. As I've said, if you are misgendered by the receptionist, it's very unlikely that you're going to stay in the waiting room.

The other thing is that all of the health services can be as inclusive as anything; sometimes it's the other clients that will persecute the discrimination, you know, in an acute hospital setting. So, you can be a Rainbow Tick accredited organisation, every nurse and doctor and orderly can be fabulous, but it's about design and system to make sure that we're kept safe, not only from the system but other patients and people within the system that can lash out against our community.

- Q. Turning to good things in the system, is it the case that in Victoria members of the LGBTQI community can access safe and welcoming spaces?
- A. Absolutely. I don't want to paint a picture that we can't, we absolutely can. The more services that are getting Rainbow Ticked, the more services that we feel we can access. There are GP trainings that are happening. For mental health obviously a GP is a very first point of call for many in our community, and there are so many very inclusive GPs.

It's still not uncommon though for LGBTI people to be actually educating GPs in their appointment. I had a recent appointment for a vein on my leg and the doctor wanted to talk about my gender identity and sexuality, and at the end of the session I said, "Who's gonna charge who?" You know, it's not an uncommon experience and, when you're presenting with mental health, you're really vulnerable, the last thing you want to do is explain your pronoun and your family make up, you know, or have any doctor ask you who the biological mother is, or all these kind of really

offensive things in a rainbow family that aren't relevant to what you presented about, and so, the onus has to be on the GPs, as I said, with judges and magistrates and everybody else, the onus has to be on the service to be able to present and do the education, and not rely on LGBTI people when they're presenting for care to be doing the education.

- Q. Can I ask you about a recent initiative: can we have the slide, please? [WIT.0003.0007.2000] This slide is entitled, "Faith Based Service Providers." Can you tell the Commissioners what that's about?
- A. So, what we certainly found in the Royal Commission for family violence, and what I've known instinctly, is that LGBTQI people can feel that accessing a faith-based service is another inhibitor.

So, churches haven't got a good rap when it comes to LGBTQI people, that's not all churches obviously, and there are many affirming and supportive churches. But many churches have been actively involved in conversion practices. I don't call it conversion therapy because I don't want to give it the weight that it doesn't need, but certainly in Victoria, as in many other states, many of the mental health services, but in this case family violence services, are delivered by faith-based services.

I know firsthand from delivering services in Kinglake after the fires that LGBTI people, one of the only buildings that was left standing was the Uniting Church and I was working for the Uniting Church and that's where we ran food relief and support. They took their animals to the RSPCA to be fed but they wouldn't come into a church, and that's a life-threatening event in the person's life, because of the perception that if they come into that church they will be discriminated against. So, it wasn't until they found out that a queer was running the food relief and I went out to them that they would come.

Similar to mental health services: right now in Victoria LGBTQI people know that one of those faith-based services has the right under law to discriminate against us. So, you know, you have to get over the hurdle and stigma of coming out, about having family violence or in this case Royal Commission on mental health, then you have to go to another service that's another barrier to know that you could be discriminated against.

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So, you know, I can't wait, I'm a very impatient Commissioner sometimes, and so, I went to these services and they said, "Of course we wouldn't discriminate", and I said, "Well, how - how can we get that message to Victorian LGBTQI people?" So I was very proud of this piece of work. Ten faith-based organisations, UnitingCare, Anglicare, Jewish Care, all signed up to a pledge to say, you know, we will not discriminate against you. They have the right to, but we will not discriminate against you, and they signed up to that and have placed that on their web pages, in their foyers. You know, VincentCare has gone on, a Catholic organisation, to get Rainbow Tick accredited, and that will make an enormous difference to send that message to community that says, you are welcome here, you have every right to this mental health service, or family violence service, or alcohol and drug service as anybody else and you are going to get fair and equal treatment.

And I think that's really what we're asking for. We're not asking for special treatment, we're asking for fair and reasonable treatment to live in dignity to access services that unfortunately we need at a higher level.

- Q. Are there any other steps that you would like this Commission to pay attention to that you think are likely to increase the mental health of LGBTQI Victorians?
- A. I think definitely looking at the system, the whole mental health system, at every point in entry, whether it's at the GP training level, all the way to acute care and how do we make sure that all the letters of the alphabet are seen.

I think putting an LGBTIQ lens over everything: over, okay, what are we doing for rural and regional people? Let's put an LGBTI lens over that. How are we making sure that gay farmers are supported, gay veterans are supported, all the other priority groups we're in?

Telehealth, rural and regional folk need to access telehealth, is that available in a culturally sensitive way to LGBTI people? I think that's the real focus, is how do we make the whole system accessible.

And then how do we let LGBTI people know that we are ready and you will be safe to access this service, I think they're the key points. I think that services run by,

delivered for and with LGBTI people are really important because, for some people they're just not gonna access mainstream service; for some people they're only going to ring Switchboard, they're only going to go to Queerspace, they're only going to go to Thorne Harbour. But for others in the community they might want confidentiality. The mainstream services need to be accessible. If you're rural and remote, if you're from a multicultural community or your partners going to one service and you want some confidentiality, or family members, so we need both.

We still need those specialised services that are LGBTI run and supported, and they need to be centres of excellence that mainstream services can look at, because of course we can't just train one round of health providers and set and forget; we need to continuously train people around ways to be accessible in our community.

There is a magnitude of things that I think needs to be looked at, but the lens needs to go over, I think, every part of the mental health service system.

MS NICHOLS: Thank you, Ro Allen. Commissioners, are there any questions?

COMMISSIONER COCKRAM: Q. Thank you, Commissioner. I'm interested, before you were mentioning about children of rainbow families. I think we've been aware that at times they also experience the stigma and discrimination of the world they live in.

Are there things that we should be thinking about as the Commission in relation to the children, and are there things that you think that we should be very aware of in relation to the impact?

A. I think I'll just tell you a quick story on the children front. You know, I mentioned through the postal survey our children's experience, it was incredible to actually see how much they took in about that. Okay, my daughter's a little different as the kid of the Commissioner, maybe had a little bit more exposure than others, whether we liked it or not.

You know, she said to me, "Mum, can I write your speech for the rally, the marriage equality rally?" And I said, "Absolutely", and I read the speech, and of course I cried, and I said this sounds like something you want to

say. Basically she said, yes, she did, and with the permission of her other mother, she got up in front of thousands at the state library and said, you know, acknowledged the traditional owners of the land and did all that, and said, "It doesn't matter what the postal survey says. I love my family and my family loves me", and thanked everybody for supporting her family and her parents.

So, yes, it does have an impact on the kids; their relationships or their families being recognised. I mentioned recently we got married. One of the things that she said was, "Now I feel legitimate." That's horrific as a parent to hear that, that she didn't feel - some way, some message that she got from society that she wasn't legitimate in a rainbow family. Now, it was in jest and joking, but it was still there, it's still in her language.

So I think children of rainbow families need to be recognised and the way to do that is recognise families, in all their forms, in all their shapes. We're over-represented as carers as well, and all the forms of -you know, LGBTI kids often in families get the responsibility of looking after their parents or anyone with a mental issue within families.

So, recognising our families in all their shapes and forms will have a particular impact to support the mental health of the whole family, but particularly our children - who, can I say, our children are doing incredibly well. Statistically our kids are doing equally as well on mental health and everything else in relation to that as kids in heterosexual families, so I want to make that point really clear.

Clearly anything that supports the visibility of rainbow families, and I think we know, we talked about language and the visibility, that's so important for kids, to feel seen and supported.

CHAIR: Thank you, Commissioner. I'd just like to ask one other thing, and thank you very much for your very comprehensive overview.

Q. I guess, I, like everyone, is very challenged by that data about the suicide rate for members of the community and trying to think about how we respond better, because

that's totally unacceptable and it's part of our terms of reference around suicide prevention.

When you talked about the fact that the point of vulnerability for people when they first come out and the importance of the response of the first person who responds to that, you had mentioned the role of Safe Schools and what you think is a potential they play. Can you just help us to understand how else you think we might improve the way in which the system can help respond to that issue?

A. It's a great thing that every state school in Victoria is a safe school. I mean, obviously at different levels, and not every young person - recent research from Minus18, which is an LGBTI youth organisation, showed us that not every young person in Victoria knows that their school is a safe school, and that's a real worry and something that we'll keep addressing.

So it may be around the doctor or nurse in school program. This is so critically important, that all the doctors, nurses, school chaplains, you know, it's so important that the very first thing they say when somebody comes out is, "Congratulations, how fantastic, how wonderful", and it be a positive thing.

Certainly, that's what Safe Schools is about, it's just, it's not a curriculum, it's around bullying and harassment. It's really important that people understand the impact of bullying at a young age can have a lifetime impact on a young person as they grow up and around their mental health.

Safe Schools is really important. Of course, it doesn't carry over into Catholic and independent schools, not that - I mean, there are an enormous, you know, growing number of - not enormous, but Catholic and independent schools that are Safe Schools. I know there's quite a market in Safe Schools material broadly in other states from Victoria, but it's an ongoing thing, we need to make sure that young people know, by language, by inclusive language of principals and teachers and everybody in levels of authority that the discrimination against LGBTI people is not acceptable in this school, in this health service, you know, in this workplace, everywhere.

And it's the vigilance of calling it out as bystanders. You know, "That's so gay" in the classroom,

every teacher needs to call that out and understand that statistically there will be an LGBTI person in that class, whether they've come out or not.

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Look, I remember talking to an aged care provider who said, "We don't have any LGBTI people in here." I said, "How many residents do you have?" He said, "Over 100." I said, "You do, you have about 10 at a minimum, go find them." How do you do that? Provide safe places, they'll eventually come out, but you can't expect them to, you have to just assume that they're there. That's so important for schools.

When we do intake, data intake at a school, if you're a school counsellor and you say to a young person, "Do you have a boyfriend or a girlfriend?", and you just ask everybody. The young boy, "Oh, I don't have a boyfriend", he might come back two sessions later and goes, "Actually I am attracted to boys." But until you get over the stigma of asking the question in the data collection, everywhere we do.

I mean, I can remember when people used to say, on data forms you can't ask someone if they're an Aboriginal or Torres Strait Islander, you know. There isn't a form now I fill in that I'm not asked, am I Aboriginal or Torres Strait Islander. And why don't we ask about somebody's sexuality and gender identity and intersex variation? You know, our community, we're probably not gonna choose to answer it if we don't feel safe, but the fact that the question is there reduces the stigma. So, it's the systematic things this we put into schools.

Schools are, you know, there's so many supportive stories of schools that are working with kids that are transitioning. You know, it's not the teachers that have the issues around kids transitioning in schools - it's just They are constantly ringing up the Safe Schools team. As late as last night I was given a briefing by the Safe Schools team: their training sessions are packed out. not that the teachers don't wanna come, because they know teachers in the frontline know this is critical for young It's really just the parents and board members of people. the school that need to get on board and see that, you know, this saves lives; we're not mucking around here, this is sheep stations, this is real, and it's so important that we change the systems, and that we give people identity and

2 that they want to be affirmed in, not what their paperwork says, and that's so important. 3 4 In school, when they transition from primary to 5 secondary school, and that's a point where young people 6 choose to transition into high school, they need to be able 7 8 to register in that school in a gender-affirming way. 9 so important that our systems are just open to that and so 10 So many fronts to take it up on, but systematically data collection recording in schools, Safe 11 12 Schools, doctors, all of those things are absolutely 13 critical. 14 15 CHAIR: Thank you. 16 17 May Commissioner Allen be excused, please? 18 19 CHAIR: Yes, thank you very much. 20 <THE WITNESS WITHDREW 21 22 The agenda has us taking a 15 minute break 23 MS NICHOLS: 24 now, if that's acceptable? 25 26 CHAIR: Yes, please. 27 SHORT ADJOURNMENT 28 29 MS COGHLAN: The next witness to be called is Dr Ruth 30 McNair, and I call her now. 31 32 33 <RUTH MCNAIR, sworn and examined: [11.27am] 34 Thank you, doctor. Can I just ask you 35 MS COGHLAN: Q. to sit forward a bit please, just so that the Commissioners 36 37 can hear you. How's that? 38 Α. 39 40 Thank you. Doctor, you've made a statement with the assistance of lawyers for the Commission? 41 I have. Α. 42 43 44 I tender that statement. [WIT.0001.0028.0001] You're 45 a general practitioner? Yes. 46 Α. 47

dignity in that, so that they can present as the gender

You have been since 1993? 1 Q. 2 Α. M'hmm. 3 4 Ο. You're currently a general practitioner at Northside Clinic? 5 Yes, I am. 6 Α. 7 8 I'll ask you some more questions specifically about 9 Northside in a moment. But you helped to establish that 10 clinic in 2009? Α. Yes. 11 12 13 Q. You are also an Honorary Associate Professor at the University of Melbourne, where you teach and conduct 14 15 research? 16 Α. Yes. 17 You are also the Co-Chair of the Victorian Government 18 Health and Human Services LGBTI Working Group? 19 20 Α. M'mm. 21 And a member of the Victorian Government LGBTI 22 Taskforce? 23 24 Yes. So, just to sort of explain my identities, as they're multiple. I'll be speaking from various 25 perspectives both as a GP seeing a lot of LGBTI clients; as 26 a researcher, I've done a lot of research in this area, and 27 as someone who contributes to policy development in the 28 29 state. 30 Thank you. I said I'd come back to ask you about 31 Northside Clinic, can I do that now? 32 33 Α. Yep. You describe it in your statement as an independent 35 and private general practice in Fitzroy North. 36 just explain a bit more about it in a general way? 37 38

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- - So it's a private general practice, we have a number of GPs and nurses and also allied health providers, so we serve the local community as a general practice does, but we also have a special focus on LGBT clients, not specifically intersex clients, and sexual health and HIV medicine. So, probably approximately half of our clients will be LGBTI, and the other half local community.

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And of the half that you've said are from the LGBTI community, most of those patients are adults?

- 1 Yes, although increasingly we have young trans and 2 gender diverse patients under 18 as well.
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- Just in your role as a general practitioner, you see private practice patients and in relation to both physical and mental health issues?
- Yeah, of course. Α.

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- How does the clinic cater for the mental health needs 9 10 of the patients you see?
- Particularly for the LGBT patients there is a lot of 11 mental health that is brought to us as part of their 12 13 consultation. So, we discuss counselling and whether that might be required, we discuss medication, but by and large 14 15 we do a lot of support and quidance around how to navigate 16 the system, but also how to navigate family, how to navigate society around their LGBTI identities. 17 think as GPs we provide a lot of support: many of our 18 clients don't progress to counselling, that just remains as 19 part of the GP-patient relationship, and then some 20 obviously would need more specialised care. 21

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- Can you then just talk about the specialised care that's available through Northside?
- So, yeah, we've appointed several clinical psychologists, counsellors and family therapists to be part of our team. We've specifically identified those people who we trust and know to be LGBTI inclusive: some are members of the LGBT community and some are not, but through word-of-mouth and through personal knowledge, we've asked them to be part of the team because we trust them and we hope that our patients trust them as well.

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- There is one clinical psychologist that specialises in 34 care for trans and gender diverse clients? 35
 - Α. Yes.

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- In terms of the clients who are using the mental 38 health services available through Northside, they access a 39 mental health care plan? 40
 - Α. M'hmm.

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- And that provides them generally with 10 sessions? 43
- 44 Α. Yeah, that's right.

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Can you just explain what sometimes happens at 46 Northside to manage the needs of those clients beyond those 47

1 10 sessions?

> Well, that's very common, so a lot of the LGBT patients that we refer for mental health support - and this might be to our own counsellors or external counsellors they'll use their 10 sessions within the first three months of the year and then have another nine months to go without Medicare rebated psychology services. So, we tend to manage them either through coming back regularly to the GP or referral back to their own counsellor, but with an arrangement that might be a reduced rate from the counsellor.

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One major issue, that there's very few, if any, bulk billing counsellors and psychologists who are in the system who also understand and are good at LGBT care, so it's a huge financial burden for those patients to then undertake further counselling without the Medicare rebate.

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- And so, this arrangement that you've described is the individual choice of a practitioner to choose to reduce the rate that they receive?
- Most of our counsellors would do that, many of Yes. the counsellors I refer to outside of the clinic will also do that, have a reduced rate on a case-by-case basis depending on the patient's needs and economic circumstances.

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But it's a major level of stress for those patients because, you know, I often see them after they've had their 10th session, they feel at a loss, they don't know whether to continue to access that service, they can't really afford to do that, so we end up having the sort of burden of care back into the primary care system.

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I've asked you about, or you've described the mental health services available through Northside Clinic. Northside is also co-located with the Mind Equality Centre? M'hmm. Α.

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- Can you briefly describe what that is, we'll hear evidence about that later but just briefly?
- Yes, I'm very pleased that Mind is presenting, I think it's a wonderful model. Mind approached us, we had a space to rent and they approached us when they were considering setting up their LGBTI Equality Centre, this was about three years ago. They had identified the need to serve this community in a more professional and detailed way in a

specific clinic. We thought that was a very good association that we could develop and it has been the case.

They've set up next to us in rooms that they rent from us. It's quite an independent relationship, but we do refer patients actively to them and vice versa to us, so it's been a very good arrangement. Being next door, it means we can go and talk to each other about clients, we can have discussions on the phone because we know each other really well, and I think our patients appreciate that too.

- Q. Can I move on to ask you about the groups within the LGBTIQ+ community that are most likely to access services and why that is?
- A. I know that Ro presented issues around barriers to services, and I totally support her words there, but I have noticed in my practice and also through my research that there's a high level of access to mental health services amongst this community.

What we don't really know is whether that level of access is commensurate to need, and I suspect that the need is even higher than the access.

 So, what I've seen in my research is that a large number of people are accessing mental health services, and I would include general practice, primary care, mental health nursing, counselling support and the hospital inpatient services in that category.

It's over-represented amongst certain subgroups of LGBTI people, particularly trans and gender diverse people are accessing the mental health services at a high rate, and also some subgroups, particularly bisexual and pansexual people, and this is what we've seen in the research around the need, there's much higher levels of need amongst the transgender diverse, pansexual, queer and bisexual groups.

Also, clearly amongst other groups, but perhaps they don't access services as readily, such as refugees, asylum seekers, people with disability and so on.

Q. One of the matters you note in your statement is that there's more likely to be access by urban dwellers as compared with people living in rural communities.

A. This is a point of great concern amongst those of us doing this work. I mean, my clinic is based in an inner urban setting, so is the other equivalent clinic in the south; we don't have clinics like ours in the outer urban area or rural areas, and this means that there's less knowledge and understanding of who to refer to in the mental health system.

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We also don't have readily identifiable LGBTI expert counsellors in rural and outer urban settings, so I think this is a major limitation, and I see this in my client group: a lot of patients come to our clinic from rural or outer urban areas of Melbourne and Victoria. point is, "Why do you come here when you live And they say, "I just don't know who 100 kilometres away?" to go to in my local area", or "I have tried a local counsellor or local GP and found that they, firstly, have no understanding of my specific issues; secondly, they felt they were homophobic or transphobic; thirdly, they didn't know who to refer me to", so the default was to come to our clinic which, you know, I hope that in a decade, two decades, our clinic doesn't need to exist, and we shouldn't need to exist: this should be the case for any person going to any general practice or community health service in Victoria, that they can access care that is knowledgeable and understands the system well enough to refer them to a locally inclusive provider.

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So, at this point we exist to serve that need, but hopefully we won't need to in the future.

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- Q. I might ask you about that more a bit later. Can I ask you now about particular groups though that you might not have much knowledge about, and lack of access by those particular groups.
- A. In research and also in the community discussions we've been having firstly I'll focus on asylum seekers and refugees. This would be one of the most disadvantaged groups of LGBTI people in Victoria. They live in Victoria, they often don't have access to Medicare. They also don't have access to the LGBTI community, and this is often related to their fear of being outed in their community or their family discovering that they're LGBT back home.

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They feel very concerned about discussing LGBT issues when an interpreter is present, because the interpreter is naturally from their own community, so there's a lot of

fear around discrimination within the community and I think this creates a huge lack of access to appropriate services and care.

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So, I understand for many asylum seekers I've talked to, and this is through my work on the Pride Foundation Australia, that they don't feel services understand their specific needs around their LGBT status. For many of them, they've come to Australia as a refugee because they're LGB or T and their own country of origin criminalises their activities. So, it's very difficult for them to prove that they're LGBT, which is one of the requirements to attain refugee status, so this is an extremely difficult position to be in.

They also have often very major trauma histories through their refugee experience. So, I fear that most of those people are not accessing the mental health system as they could and should be doing.

Another major subgroup are people with disabilities: Ro mentioned them in her evidence. We know that people with a disability who are also LGBT often have difficulty understanding their sexuality or gender identity in relation to LGBT community. So, they don't feel like they can access community very easily. They don't feel they can discuss their LGBT status openly with a health provider for similar reasons that a family can be very involved in a caring capacity for people with disability, are often in the room or closely connected with the health provider, so issues of confidentiality are very difficult to maintain.

A person can feel that they can't expose or disclose their sexuality or gender identity to a health provider because of fears that their family will discriminate against them, or worse, reject them.

- Q. You say in your statement that further research is required with respect to how these groups access mental health services?
- A. Definitely. They're quite underserved, both in the health system and in research.

Q. Can I ask you now about the most common barriers to accessing mental health services, and in particular for you to please address the internal barriers and the external barriers: just starting with the internal barriers and what

that includes?

A. Just to put this into context, I did a piece of research for Beyond Blue about four years ago: they asked me to look at lesbian/bi women and I extended that to queer women and transgender diverse people and their mental health and access to the mental health system. So, we did this by doing an online survey, that was responded to by about 1,600 people in Australia, and then did some key informant interviews with health providers and services as well.

The issue there, we obviously did a lit review and tried to understand what were some of the key barriers that were uncovered in the literature as well as my understanding from the clinical practice. So, we made a division between internal and external barriers to access, because they're important.

 So, firstly, internal barriers: I mean, these are some things that might arise because of homophobia, internalised homophobia, biphobia or transphobia, and just to define that: that would be, let's say you've grown up in a family that often vilifies gay or lesbian people. There might be commentary around media engagement with that group, so the child is learning and listening to this discussion and can take on those values for themselves. But as it emerges in their own mind that they're lesbian, gay or bi or trans, they've already learned these negative stereotypes, so it becomes internally focused and they say, well, that means I must be wrong, evil, inadequate in some way.

So, if one has this feeling of internalised homophobia, biphobia or transphobia, it can mean that you don't feel worthy of accessing support, that this is not a legitimate issue, and so, that can be one of the major barriers to seeking support. So, one might describe, for example, I've got a young bisexual person in my practice at the moment, she's about , she describes very clearly this idea that she's had throughout her life that being bisexual or lesbian is just completely wrong. She's from a faith-based family.

And so, she's grappling with this constantly at the moment, you know, is it right or wrong? You know, which is my moral compass? How do I determine that when my family are so clearly on that side of the equation? And, I'm the first person that she's discussed her bisexuality with.

She feels that this is immoral for her to feel like this, and so, I'm trying to work with her on how to reframe her moral system, which is a huge thing to do for anyone, in a situation where her most close support comes still from her family.

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So, I think for this young woman: she's , she's been grappling with this for years, has only just come to a GP to talk about the issues. There's no way she will access a mental health provider at the moment because she feels that she would just have to reveal this immorality to someone else, so it will require several months or years of discussion before she can access. So, from her perspective, that is a very major internal barrier, this sort of moral compass.

Q. One of the things you mention in your statement about one way to overcome that internal barrier, in a system sense, is to enhance mental health literacy?

A. Yes. I mean, I'll come to that a bit later perhaps, but the idea that - I mean, this woman isn't attached to the LGBT community at all, so I think this would be a very difficult thing to do, to draw on community assumptions or advice - she's not connected yet, perhaps she will be in the future.

But that's one idea more broadly, is to look at how we can communicate this to the LGBTI communities, to say, you are allowed to access mental health services; in fact it's a good idea; in fact it's better than that, it's an excellent idea and there are great people out there who can help you. So, this is something that's emerging in our communities as an important message for health promotion, not just for mental illness, but for this young woman that wouldn't work.

Another of the internal barriers is an idea of needing to be self-sufficient. I think we've seen this, if we look at the gendered or binary gender of the mental health system access, we know that women are much more likely to access counselling than men, for example. It's a similar issue around men in our society needing to feel self-sufficient, sufficiently regard themselves as the sole person who is guiding their own life, and so, to let that guard down and say, no, I do need a bit of help here, it's okay to get some help, I think that's also a problem for some LGBTI people. They just feel that this should be part

of what they do anyway in their life.

Turning to external barriers: I think Ro's really touched on this largely, but it's partly about knowing who to see who will be LGBTI inclusive; that can be really difficult to understand. Perceived discrimination Ro's talked about as well.

 I wanted to touch on an issue of continuity of care because I think this is another major external barrier. So, if a person has attempted to access - whether it be a primary care provider or a mental health provider - and found that person to be lacking in their LGBTI inclusiveness or knowledge, then they might doctor-shop: they might work through the system to find other people and in the end might have seen six, eight, 10 different people. I've got many patients in this category who have seen many, many counsellors but only for very brief periods of time.

So, first they lose the motivation to see more counsellors because they don't feel they've had an adequate level of support or benefit, so they've lost trust in the system, and so, we've lost that opportunity up to a point to encourage them to see someone on a regular basis.

So part of what I'm doing with patients in that group is re-engaging them with the system, saying there are supportive, inclusive counsellors out there, I know them, I've worked with them, I've had good feedback from other people in your position, and trying to re-engage and encourage continuity, so a relationship that's long enough to develop a deeper understanding of the person and therefore reach a deeper level in counselling.

Q. Can I ask you about poverty and financial inequity being another major barrier to accessing mental health services.

A. So, I know the Commission has received a lot of advice already about financial inequity: that's not new to you at all. But for this group, we know that poverty is one of the underlying issues that create health inequalities for LGBT people.

I'll just give you an example: this is a woman I interviewed for one of my research projects a few years ago. She was at the time, lesbian, had had a lot of family violence as a young person and had left home early

So, she had left home as part of my homelessness research. at about the age of 15 because she felt that her home environment was not supportive: more than that, was violent.

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She'd been homeless for many years, at least a decade of her life, from about 15-25, and as a result of that had had no access to education or training. And at about 25 managed to exit the homelessness system, find accommodation and start training.

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So, at the age of 29 she was looking at her peers and saying, they've all achieved their degrees, they've achieved status in their various occupations, they've got into a committed relationship, they're starting to think about buying a house, and she was reflecting on her life: she was still training, she wasn't in a committed relationship, she still had unstable housing, and she was extremely poor.

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So, you know, she was an example of what happens frequently in this community, with repeated or confounding factors that affect mental health and the ability to progress in life: it's a repeated story equally for people who are transgender diverse, for gay men. This is a huge issue around accessing education and training, and therefore accessing a good workplace and secure employment and income.

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So, with that as a background, many, many LGBT people don't have enough money to finance through the private mental health system and have to rely on the public mental health system, which is difficult to say the least.

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- Are there barriers greater for certain groups, and if you could address what you describe as marginal and emerging identities as a starting point?
- So, you'll be very aware that this community is diversifying rapidly. We have a hugely diverse group of young people, and people of any age actually, who are understanding their gender in a diverse way now, with many, many different terms that are out there, increasing all the time which I find difficult in training, because I'll give people a set of terms and then in a few months the terms have changed and they come back to me and say, "You didn't tell me that term", and I say "I've only just learned it myself."

 For people who are in these - what I'm calling emerging groups, emerging to me, not necessarily to them - so they might be what we call questioning their gender or sexual identities. "Pansexual" is a common term that's being used in the community at the moment, and that relates to people who have attraction to people of diverse gender. The queer community is very diverse as well, and gender diverse obviously.

So, these emerging communities don't have that connection with like-minded others necessarily, so they can find it very difficult to find support groups that are like them. They can feel marginalised both in mainstream society and what might be called the heterosexual cisgender normative society, but also they can feel marginalised within the LGBT community.

And so, these people have less word-of-mouth, so they have less ability to listen to peers and understand what's out there, you know, what is an affirming general practice, what is an affirming counsellor, and this is one of the key strengths in the LGBT community, that we do talk with each other, we discuss who's out there, who's safe. We talk to people about which physio might be good - it's not just mental health, but let's focus on mental health. So, I think the emerging or marginal groups have less ability to understand the system and to navigate the system in that way, as well as being more marginal in terms of their mental health, so that's one group that's particularly an issue.

Another with greater barrier would be people who are using drugs or alcohol. We know that that's a significant additional factor or possibly a factor that's creating the mental health issues in the first place: the chicken and egg situation, don't know what comes first sometimes. But certainly we know there's a lot of alcohol and drug use as self-medication for mental health problems in the community.

Quite often people gather together in a group where everyone is using the same drugs or using a lot of alcohol, and this is a group that might be trying to gain support from each other but not being able to access the broader mental health system very well.

I wanted to mention another group which is around people with trauma histories. So, again, if we're looking at perhaps underlying reasons for the high, the very high mental health inequalities in this group: one of the underlying issues seems to be trauma, and not just one episode of trauma but repeated re-traumatisation for people. This might be a trajectory from family violence or family rejection, through to rejection or trauma within the education system, in workplaces and within society generally.

So, these people, again, have even higher difficulty finding appropriate services: you know, services that both understand their trauma history as well as understand their LGBT status and other disadvantage. So, it's a concern that the most vulnerable members of this population can't access appropriate care.

- Q. Can I ask you now about what the enablers are for people accessing mental health services? So, what makes a good service?
- A. We tried to look at this from a research point of view in the Rainbow Women's Society I talked about before that was funded by Beyond Blue, in some work I've done with alcohol and accessing alcohol services for lesbian and bi women. The enablers seem repeatedly to be the same. So, first, accessing a GP that is supportive: that seems to have a high level of agreement in the surveys, and I understand this to be about, if one has a supportive GP and can come out to that GP as LGBT, then this can enable uncovering of other related issues.

And so, one's mental health that might have been quite suppressed in the conversation, you know, a person would often come to a GP first for their physical health issue, the mental health's in the background, they're testing the system; is it going to be supportive? Okay, yes, then I'll disclose that part of me as well.

 So I think having a GP where there's some continuity of care, there's a relationship developing, there's a level of trust, the more difficult issues are raised over time, and then this same GP can refer out to the appropriate services. So, that's one enabler that's incredibly important.

Another is community support. So, I've mentioned this

already, but if there is a supportive peer group who is like-minded and has collated information about what's out there in terms of support, and shared that knowledge in the group, and indeed encouraged people to access supportive care, then that will be an enabler for mental health support and care

As I said, I think people who have found such a group have a much better chance of recovery because they can find the right people to go to and be encouraged to maintain that relationship.

- Q. What about having reliable information about what services are available?
- A. Yeah, I mean reliable in terms of word-of-mouth: I think at times people have different experiences in health services, and this can be very difficult when I'm training service providers. You know, we can't be all things to all people, and I know that at our clinic we've received criticism because we've not dealt well with a bisexual person, we've not understood a trans or gender diverse person very well. I mean, there's a high bar that we've set and we need to be criticised to be sure that we're maintaining a good standard.

Having said that, some people will have a uniquely bad experience based on a difficult receptionist, or it was a bad day for the clinician: that's not an excuse, but that person has had a bad experience, so unfortunately that can filter through peer support groups and that clinician or service is no longer acceptable in the group. So, I think up to a point that can be a very difficult situation, because in fact that group or service might be entirely appropriate.

So I think - we'll come to peer support in more detail but I think that's one of the very difficult things for a peer support organisation to do, is to navigate how these services appear to individuals, yet how they might be supportive to the whole community.

- Q. You also mention in your statement access to counselling services online can be particularly important for young people.
- A. Yep.

Q. And so, can you just tell the Commissioners about

that?

I've talked with Headspace quite a bit about their services, because clearly there's an online Headspace, and they've set that up deliberately for both rural and remote young people, but also young people who just can't physically attend a service. They have found that to be very effective.

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Recently in the last two or three years Headspace have started collecting data on sexual orientation and gender identity of the people who access their online service, and it looks like in most areas it's between 20 and 25 per cent of the young people accessing the online Headspace service.

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This is much higher than you would expect from population data, so I think this supports the theory that we've been developing for quite a while that a number of LGBT people would put their toe in the water in an online service: let's test the system, let's see if I'm going to get some support that's affirming of my sexual orientation. gender identity, and having had that affirming care in an online service, they will then be more likely hopefully to access face-to-face services.

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So, that's certainly the case at Headspace, and I can see there's a few emerging online services that are specifically designed for LGBT people with mental health Out and Online is one example. ReachOut is doing issues. Beyond Blue are looking at some some work in that area. online support as well they've specifically targeted at I think that's an incredibly valuable LGBT people. addition to the mental health service.

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It doesn't replace face-to-face services in any way, but I think it enables access for people who are rural or remote, and hopefully enables the building of trust in the system.

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- Can I take you back to Northside Clinic and ask you some questions about the inclusive care that's provided there.
- We pride ourselves in being a high quality general practitioner which is accredited and so on, but we also have additional processes that we have developed over the years, and mostly through word-of-mouth and feedback and internal discussion on how to be more inclusive for I'm deliberately not discussing people with LGBT clients.

intersex variation because we haven't yet enabled those systems in our practice and we need to.

So, for LGBT clients, we start with, what's the face of our clinic to the community? So we do advertise our service actively in the LGBT community. We attend midsummer carnival, we have a stall, we run blood pressure checks and things, but it's really just to help people know who we are and meet us.

You know, we have the rainbow flag at the front. Having said that, that's not the only thing. If you just had a rainbow flag and nothing else, that's actually a really poor approach, because people can let their guard down a little. As Ro said, she feels more comfortable when she sees the rainbow flag, but if nothing happens after that, you've let your guard down and you've been disappointed - that's no good.

So, you know, that imagery on the front of the clinic around saying that we're LGBT inclusive, having imagery that's appropriate, is the first step. Then training the receptionists to be appropriate, to use appropriate language. I mean, these are very simple steps, it doesn't cost money, it's just a process. To understand that we don't have to use titles, we don't have to use Mr, Mrs, Ms, Dr, this is not relevant to one's health care in any way and it removes a significant barrier for some people.

An example is we used to send - we still do - send letters out to our patients reminding them they need their cervical screening. The letter used to say "Dear Ms X"; well, we have a number of trans men who need cervical screening as well. If that letter says, "Dear Ms X", they will be horrified, it would be completely inappropriate, and it would probably mean they wouldn't come in for their cervical screening let alone anything else. So, there's no need to have a title in letters on their medical file so we've removed that altogether.

 Likewise when we call names in the waiting room, we try to ensure we're calling the appropriate name, not the so-called debt name or their birth name, that's particularly important for gender diverse and trans clients.

But also some LGB clients change their name, and this

is related to difficulties in family circumstances, so we need to be sure that we're using the name they select rather than their Medicare name. So, we've trained receptionists to be appropriate around not using titles, using appropriate gender, using appropriate names, and also being very careful around confidentiality.

Our clinic is a melting pot and a meeting point, so people often see each other in the waiting room, that's not always a good thing. The receptionists sort of look out for that and can help negotiate what's happening in the waiting room.

 And then, attempting to improve the way we offer services within the consulting room, and that's around again confidentiality, training ourselves in the LGBT community issues that are most important, and the top of the list is mental health and suicide prevention, understanding drug and alcohol issues that are specific to subgroups in the community, engaging with appropriate counselling staff and so on.

I think another big part of it is developing our referral networks, which we do gradually over time, based again on feedback and meeting different providers, so understanding who is supportive of this community, and not just supportive, but affirming of LGBT status.

So, these are all things that are fairly easy to institute in a clinic such as ours or any other general practice.

Q. Commissioner Allen mentioned this morning the Rainbow Tick: is that something that Northside Clinic has or wants? A. M'mm. We have looked into doing Rainbow Tick actually, just to say we've got it. I think we have pretty much done all of the things that would be required in the Rainbow Tick, and we haven't got Rainbow Tick at the moment.

I feel that Rainbow Tick is one end of the spectrum of inclusive practice. It's most helpful for large organisations that have an infrastructure that can introduce all of the system change that's required by the Rainbow Tick accreditation. For smaller practices such as ours and health services, we don't have the infrastructure to create that enormous amount of change, but we do have a

set of very clear directives that we've provided for our staff.

- Q. You mentioned the role of peer support workers briefly earlier. Can you just address that topic now and particularly with regard to your academic work on the subject?
- A. So, I think if there's one system reform that you could focus on most for our group, it is supporting the peer support work that's happening in our community. This is partly because, as Ro was saying, it's about resilience building, but mostly because a lot of the LGBT patients I see in my clinic rely almost entirely on peer support as their mental health support.

So, as we've said, there are a lot of barriers to accessing the mental health system. For those particularly marginalised groups, the only level of support they get is through a peer support group, and this is not ideal, but it's the reality at the moment.

So I think what we're needing to do is integrate the peer support system into the mental health system in a much more effective way: to have methods of cross-referral so that practitioners know these peer support groups exist and can refer to them, but also to have methods for the peer support workers to refer into the mental health system, and at this point that's not happening effectively.

One of the key points is that, if peer support workers are looking after a group of LGBT people with significant mental health concerns, generally speaking they have not had adequate training to do that, and they know that themselves, they're crying out for some training and support, because this is a complex group of people, often with complex trauma histories. Within one group setting, particularly when there's - well either online or face-to-face - networking in the group, there can be quite a lot of lateral violence in the group. Difficulties with policing identities or with understanding who is in a relationship with who.

So peer support workers need a great deal of training to understand how to deal with those issues, how to address lateral violence, for example, in a safe way so that the group is sustaining and not re-traumatising. So, I think that's a huge issue that can be addressed within the

Victorian health system.

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And so, in addition to that change, there are other Ο. systematic changes that you perceive as desirable. please address - and you've already touched on this - but the idea of mental health practitioners receiving adequate training in relation to LGBTI inclusivity, and so, you said that needs to be more broadly applied?

We have a problem with LGBT inclusion in curriculum at all levels at the moment. It's verv piecemeal, it's not embedded in curriculum in most training organisations. It happens, if there's an individual champion, and sometimes that appears for a few years and then disappears again if that champion has left the organisation, and this would be whether it be at university level, at a training organisation or at a continuing professional development level. So, I think there's a major issue at the moment in understanding how are we going

to address more systematic training within the sector.

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> There's certainly individual work happening. been working with Queer MD which is a group of LGBT medical students at Melbourne Uni and they've got colleagues both at Monash and Deakin. They are raising issues of needing to have LGBT inclusion in the curriculum, and have been for a number of years. It's still regarded as quite a marginal issue in the curriculum and really only appears in the student conference that is student led and delivered. you know, that's at this stage falling on deaf ears by and large.

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And this is partly because there's a huge competition for curriculum and do we have - where do we sit in the hierarchy of need. But I think we can make the case, and we have made the case already, that there's a huge need in this community that can be addressed through curriculum change.

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Okay, that's a systematic approach to understanding that LGBT needs to be embedded, just as Aboriginal and Torres Strait Islander health has been embedded in the curriculum over the last 20 years. Easily done, I hope, over time.

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As Ro said, I think a lot of LGBT people resent having to train their health provider in their own specific identity, and this is a conundrum that I have in training

health providers, because on the one hand I'm saying to people, please listen to your patient, listen to your client, try to understand their perspective, their individual identity, how does that play out in their life? But that can easily become a little mini training exercise from the patient to the clinician. And, as Ro said, that was a very difficult thing that they identified and understood in their own life.

> If people had done that two or three times, they start to resent it so much that they maybe decide not to come out to a new provider, it just becomes too difficult, and their own issues are lost in that. So, we need to avoid that.

- Q. I'll just ask you briefly about some other systematic changes and then move on to what you ultimately would recommend. You say that there needs to be greater work done on mental health promotion.
- A. M'hmm.

- Q. There are good examples of that with the National LGBTI Health Alliance and what's been produced there. In addition to that, further research into LGBTI mental health and health care needs to occur, and further data collection by mainstream services.
- A. Look, just focusing on mental health promotion for a moment, we're starting to build a literature around resilience. So, it's been difficult because until quite recently we've had to focus in on the negative statistics to raise the awareness and to make the case for curriculum inclusion in training and to make the case for inclusive practice.

 The argument has been, well, there's a much higher need, there's a much higher burden of mental illness in this LGBT community, so we need more focus and more attention. That can be quite pathologising for the community; it is very pathologising. A lot of community members, whether they've experienced personal mental health problems or not, worry about the fact that they'll be assumed to have a mental health illness because they're LGBT.

So I think, to try and avoid or reverse that approach, I think we need to be looking at resilience building as a really important strategy, and also how we're already enabling resilience in the community, it comes back a

little bit to the idea of internal barriers to seeking help.

So, if we've come from a point of saying, we have internalised homophobia for example, how do we overcome that, and it's partly about systematic change clearly, but partly about, let's build our own LGBT community support and resilience, let's celebrate ourselves, let's understand what we're good at: we're very good at peer support, we're very good at connection, we're very good at reaching out for those marginalised groups. We're better than many other communities at doing that, let's celebrate that and support it.

So, I think we can make a greater effort to do that. I mean, the Victorian State Government have done some amazing work recently in leadership training for young LGBTI people, and those new emerging leaders are starting to look at this idea of resilience and positive support, supporting our positive mental health, so that's a huge new wave I think that we can look forward to over the next few years.

The mental health promotion: there's a little bit happening, for example there was a document produced about mental health first aid, specifically for LGBTIQ communities. It's a nice brief, four, five-paged document. A bit of guidance for whether it be peer support groups, or parents or schools, any level of community, to say how can we pick up early signs, early intervention, and prevent longer term problems.

Another lovely piece of work that is about to start is primary prevention for families around trans and gender diversity. So, building an education piece for families, and this is particularly looking at multi-cultural families: you know, how do we support the family to understand what is trans and gender diverse, that it's a nominal variation of gender identity, and that we can helpfully help them to understand this before they present negative attitudes to their children. So, I think that's going to be a really lovely piece of work to focus in on in the next few years.

- Q. Can I ask you then, just finally, in relation to the key changes?
- A. So, there's been work done on this over the last

10 years or so. The key piece that I'll refer you to is: A Closer Look At Private Lives. So, this Private Lives 2 was a big LGBT health survey that was done in 2010. Beyond Blue sponsored some additional analyses of that survey to look at mental health, and out of that analysis, plus the work that we were doing on the LGBTI ministerial advisory group at the time, we developed a policy and program framework for mental health support.

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And really, it looked at a three-level system or three-tiered system of support in the mental health system. So, we felt that the majority of LGBTI people needing mental health support should be able to access that through the mainstream system, but that all areas of the mainstream system needed to be LGBTI inclusive. So, that would involve, as we've discussed, training, accreditation, whole-of-system change. Whether that be Rainbow Tick or not is a question to be discussed.

Then the second tier were mainstream services that had an embedded LGBTI stream. So, an example of that is the Mind Equality Centre, for example, or perhaps more recently the community health system in Victoria. There's a new LGBTI inclusive practice toolkit that's going to be released in a couple of months that is encouraging a sort of embedded LGBT stream within community health. So it might be identified practitioners who are LGBTI champions who would preferentially see those clients.

Then the third tier would be for that minority of the most vulnerable of LGBTI patients who for many reasons don't feel comfortable to access mainstream mental health services and who need peer-led, LGBT-led system. So, that might be people who go to Thorne Harbour Health, work through Switchboard, go to Drummond Street services.

Again, at the moment all of these LGBTI-specific services are based in urban areas: there's very few, if any, that will be in the rural sector. So, if we had a concerted effort to develop a three-tiered system like this, we would need to address specialist services in rural areas as a key point, and/or more online and teleconferencing accessibility.

Q. Can I just pick up on, just finally, one question you raise, the point about Rainbow Tick or not. Could you just very briefly address that?

A. I think we've learned some lessons from the family violence sector in the last couple of years. So, there was a recommendation from the Family Violence Royal Commission that all family violence services in Victoria should receive the Rainbow Tick accreditation, and that was an astounding recommendation, it was fantastic actually to acknowledge the need for that training.

But it created problems on the ground, because many family violence services are tiny, they have a very small staff group, a large volunteer group as well, and it emerged that, for those smaller organisations, it was very difficult to obtain a Rainbow Tick: it's an expensive process, it takes a lot of time. I think VincentCare, it took them a couple of years. They employed a worker two days a week for that two-year period to enable Rainbow Tick, so that's not possible for small organisations.

I think a recommendation that's broader that's around LGBTI inclusive training and system change would be appropriate, because then that can cover off small organisations, it can cover off organisations that are already doing the work, such as Northside; it doesn't have to be Rainbow Tick, there can be a number of levels before that.

So, I think Family Violence in the end have come down to an idea that, in one region there's a Rainbow Tick accredited service, all the other smaller services do some training in the area, and then can work with that Rainbow Tick accredited service as the local peak, if you like. That seems to be a better way to navigate that approach to the system, and this would certainly apply for the mental health system where there are many small services that are operating that probably can't access Rainbow Tick but could do some work in upskilling.

MS COGHLAN: Thank you, doctor. Chair, do the Commissioners have any questions?

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for your evidence, I have two questions. One, is there data about the economic status of LGBT people?

A. Yeah, there is. So, the HILDA survey, which is a national household survey, is starting to indicate that

some groups of LGB - and we don't have trans or gender identity in that survey - but the LGB community have a lower economic status than equivalent heterosexual.

There's also some data that will be coming out from the Victorian population health survey. We hope that report will be out in a couple of months. I'm not at liberty to give you that information at the moment because it hasn't gone to the Minister, but I have seen the data and it confirms significant areas of economic disadvantage for LGBTI community in Victoria.

Q. Thank you. My second question is something that's been raised by GPs before, and I'm talking about the GP, not the psychology bit, that the MBS fee schedule, how do you view it with your interest in LGBT, it tends not to to the extent you're driven at all by economic incentives, it doesn't encourage lengthy consultation and so on.

A. Ouite.

Q. Can you comment on your perspective on that?

A. Yes, that's totally correct. So, example: if I see a person in 15 minutes, which will be a standard general practice consultation time, that's a level B consultation, so that's remunerated at a certain rate. If I see them in 30 minutes, which is more likely for some of the complex issues that I have to deal with for LGBT community, I'm remunerated at a level C, which is about a third again on top of the level B rate. So, it's not double. So, the more level Cs or longer consultations I do, the less money I get per day, and that's economically a problem. I'm trying to run a practice.

I mean, we've talked with Mind Equality recently about the fact that they're bulk billing most of the providers that got to that - sorry, the patients that go to that service and that's not sustainable in the long term. Equally for our clinic it's not sustainable to bulk bill, we have to add an additional charge for two-thirds of our patients.

So, when we're talking about complex mental health care, and particularly in a scenario where a patient cannot or does not want to go to a mental health provider, the burden of care rests on the GP. We have extended 30 or 45 minute consultations with patients on a regular basis with minimal remuneration, all bulk billed, so this doesn't

work.

CHAIR: Q. Thank you very much. I'd like to ask just one other question which goes to that issue of the burden of care. I was mindful throughout your evidence of talking about the fact that many of the people you see are reluctant to go and seek access to specialist mental health services, and I noted you said also for those who are accessing peer support, many times people are overwhelmed by the complexity of the mental health issues they're presented with.

What role do you think there is for secondary consultation? If people don't want to access the specialist mental health services, how can you bring sometimes that greater expertise you might need in the management to reduce that burden of care, I guess, or share the burden of care?

A. I think that has a huge role to play. An example is, the Monash Gender Clinic is now offering secondary consultation for GPs. So, Jaco Erasmus is the Head of the Monash Gender Service and is also a psychiatrist, sees a lot of gender diverse and trans patients in his private practice as well. So, he started offering a secondary consultation service in the last couple of years, particularly for rural and remote GPs, but also anyone in the urban sector.

It means that a GP can see a patient who's trans or gender diverse, talk about their complex needs, talk to Jaco and get some discussion about how to deal with whatever it is, and it might mean that they don't have to see Jaco at all. So, I think that would be fantastic if we can have a service that is extended beyond transgender diverse to all the LGBTI communities.

Just to touch on intersex for a moment: most GPs that I know, and I'm certainly in that group, don't have expertise in seeing people with intersex variations. The literature is still really poor on what are the mental health concerns for people with intersex variations. We've touched on it a little bit in Ro and my evidence, so that needs more research. But, you know, to have secondary consultation based on - and whether it be children or adults, who have intersex variations, if we could talk to a psychiatrist or endocrinologist about these issues, we may be able to retain that patient in our system rather than

1 2	refer them out for specialist care, which I think is a principle that works for the health system generally, of	
3	course.	
4 5	CHAIR: Thank you.	
6	CHAIR. Hair you.	
7	MS COGHLAN: Thank you. May Dr McNair please be excused?	
8 9	CHAIR: Yes, and thank you very much for your evidence	
10	today.	
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12	<the td="" withdrew<="" witness=""></the>	
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14	MS NICHOLS: The next witness is Associate Professor	
15 16	Michelle Telfer. I call her to give evidence now.	
17	<pre><michelle [12.29pm]<="" affirmed="" and="" examined:="" pre="" telfer,=""></michelle></pre>	
18	THICHEBUR TEDEBY, ATTITUDE and examined.	
19	MS NICHOLS: Q. Dr Telfer, are you a general	
20	paediatrician and adolescent medicine physician and Head of	
21	the Department of Adolescent Medicine at the Royal	
22	Children's Hospital?	
23	A. Yes.	
24	A. ICD.	
25	Q. With the assistance of the Royal Commission have you	
26	prepared a statement addressing the questions we have asked	
27	of you?	
28	A. I have.	
29		
30	Q. I tender the statement. [WIT.0002.0003.0001].	
31	Have you been at the Royal Children's Hospital for	
32	seven years?	
33	A. Yes, I have.	
34		
35	Q. Are you President of the Australian Professional	
36	Association for Trans Health which provides a support for	
37	the network of professionals who work in trans and gender	
38	health?	
39	A. Yes, that's correct.	
40		
41	Q. Are you the lead author of the Australian Standards of	
42	Care and Treatment Guidelines for Trans and Gender Diverse	
43	Children and Adolescents?	
44	A. Yes.	
45		
46	Q. Has that guideline now become internationally	
47	recognised?	

- 1 A. It has.

- Q. Can you tell us, in short, what is meant by the term "transgender" so we can be clear about that?
- A. Transgender?

- Q. Yes.
- A. So, transgender is an umbrella term that covers a number of different trans identities, and a young person is trans when they're sex assigned at birth, which is determined by their physical anatomy, does not match with their gender identity. Their gender identity being the deep inner sense of whether someone is male, female or somewhere in between.

- O. And, what about "gender diverse"?
- A. Gender diverse is similarly used in this context as an umbrella term. As Commissioner Allen and also Dr McNair had described, there are lots of different terms that cover this population. Trans and gender diverse were used as the overall term that pretty much encompasses everyone, and certainly for the purposes of today I'll use trans and gender diverse to encompass everyone.

Q. Thank you. I want to ask you about how the mental health outcomes of trans and gender diverse young people compared with those in the general population. We've heard a little bit about that already today. Can I just ask you, from your perspective on the basis of the experience you've had, do trans and gender diverse young people experience higher levels of discrimination, stigma and bullying?

A. They do. The best evidence we have in Australia comes from a study that was nationwide, online study, conducted in 2016 and published in 2017. It's known as the Trans Pathways Study and that looked at 859 young people between the ages of 14 and 25.

 This particular population of trans and gender diverse young people were nationwide not particularly well supported in terms of their physical and mental health. The outcomes are frightening for us who work in this field, where 75 per cent had been diagnosed with depression; 72 per cent with anxiety; 80 per cent had tried to self-harm at some stage, and 48 per cent had attempted suicide.

We know from our own anecdotal experience with the

gender service that, with excellent family support and medical services, including specialist services, that these rates are somewhat lower, and certainly what we see is, a large number of young people who come in having experienced self-harm and suicide attempts who improve with regards to their mental health once they receive that support.

- Q. The study you just mentioned, that's an Australian study?
- A. That's right, was conducted across Australia.

- Q. Is there international data to indicate that there's a demonstrated risk of increased homicide when openly identifying as being trans or gender diverse?
- A. That's correct. That data comes from the USA. We don't have comparable data here, but the data in the US certainly suggests that being trans and gender diverse, and expressing that gender diversity is a major risk for homicide.

- Q. What are the sources of stigma that trans and gender diverse young people experience?
- A. I often go back to a common definition of stigma, because I think it's helpful to think about it in this way, in that, stigma is a mark of disgrace that really isolates a person from others or separates a person from others. We know that having depression or anxiety, having self-harm or attempting suicide, causes stigma.

But what we know from trans and gender diverse young people, is that, they experience stigma just for being themselves. So, being transgender alone is enough to have a mark of disgrace. And, with that stigma comes obviously the discrimination, the social exclusion, the family rejection and so forth, and that leads to the mental health problems that we've discussed.

So, there's almost like an exponential rise in stigma because you're stigmatised for who you are, and then stigmatised for the negative consequences of that original stigma.

I think, in my view, that's the reason why the mental health outcomes are so poor in this group, and are so difficult to change, because the stigma is experienced not only in wider society, but the young people experience stigma from their parents, from their siblings, from their

peers at school, from their teachers, in all sorts of aspects of their lives.

And I've witnessed myself in my clinic, only just in the last few weeks, having a parent tell their child, their very intelligent, empathetic, very generous child, that they are a disgrace on the family, and that sort of thing really affects us as clinicians, and I couldn't imagine what that must have felt like for that young person.

So, we see it firsthand as well as hear about it from the young people as an experience of their daily lives.

- Q. Have you had experience of transgender and gender diverse young people failing to complete school despite having high academic ability?
- A. Absolutely. Trans and gender diverse young people, when they're at school, experience a high degree of bullying and hostility and sometimes even physical assaults at school, and often can't persist with their schooling because of that hostile environment. A lot of these young people are very high achieving, very intelligent, have great academic potential.

 Many go into distance education and try and complete their schooling that way, but that creates a whole other level of social isolation and it can be really difficult coming from a place of being isolated to really reach that potential and get through to where they should be, which is being at university and achieving high results.

Q. Is there a longitudinal cohort study which is being carried out by the Royal Children's Hospital Foundation, and partly funded by the Victorian Government, looking at outcomes for trans and gender diverse young people over a period of 20 years?

A. Yes, that's correct. So, there's very little longitudinal data looking at long-term outcomes for children and adolescents: partly because the specialist care that we provide really has only been in existence internationally over the last 20 years.

So, when the State Government gave us the funding to commence a specialised gender service we felt it was necessary to evaluate our outcomes. We started to measure with everyone who came into the service, their physical health, their mental health, their family function, their

level of bullying and other measures really to look at where they're at at the beginning.

We then follow these young people with surveys as they go through the clinical service, and we're currently funded for four years, but I ambitiously called it Trans 20, hoping that we would be able to keep it going for 20 years, because I think that's where its value lies in looking at that long-term data and actually using that data to improve outcomes into the future.

- Q. Do preliminary results as at about now show a link between experiences of bullying and mental health issues, with 17 per cent of trans and gender diverse young people who are experiencing bullying showing a high risk of suicide, compared with 8 per cent for those who didn't experience bullying?
- A. That's correct. So, there was a high rate of bullying itself compared to the general population, and those that were bullied were significantly worse off in terms of suicidality.

- Q. Could I ask you about the mental health outcomes of trans and gender diverse young people compared with the broader LGBTQI community?
- A. Yes. So, when we look at the suicide or attempted suicide rates in the trans and gender diverse community, they are higher than any other group that I'm aware of. I think that, in terms of social acceptance of trans identities, we're still quite a long way behind the acceptance of the lesbian, gay and bisexual communities.

We saw from the marriage equality debate leading up to the postal survey that this was certainly evident, with the "no" campaign actually using transgender children as a source of fear for those who might be thinking of voting for marriage equality.

They produced this campaign through the television and through social media which really did demonise trans children in the sense that what they said is, with this slippery slope argument, that if we have marriage equality there will be more transgender children. And, not only did they suggest that this is possible - because it's not, no-one can create someone's gender identity - but not only did they suggest it was possible, but they suggested that that was something to fear and something parents would or

should be concerned and worried about.

Q. What do you say about the notion that children don't absorb the nuances of adult debate about social policy?

A. Yes, well, I think as we've heard from Commissioner Allen, children are very perceptive with regards to what's going on in the world around them; and, not only that, they're very IT savvy and able to navigate the internet and social media really well. But even really young children pick up on what's being said, whether that's in the home, at family events or at school.

It's just like, I suppose, being in a room where you hear your name mentioned, you sort of turn around to see what's being said, and for children and young people who are needing to be vigilant about their environment and knowing when it's safe to express how they feel or not, they are vigilant, hypervigilant, when it comes to information that's out in the media and the noise that's being created with this.

I think, when social commentators talk about transgender children and demonise or vilify them, they're really projecting that view to the adult audience and to try and create fear within that adult audience, but the people that get hurt the most are the trans children who are experiencing it in that very personal way and who are taking it all in.

We know they're taking it in because parents tell us how their mental health is affected at these times where there is a lot of noise in the media. But also, at the Children's Hospital where we're known as a very gender-affirming safe space to be, they'll come in and tell us about how it's really upsetting them, and they look to us for reassurance, that they're okay, that they're worthwhile and that they deserve to be loved by their family and taken care of by their doctors.

 Q. Can I ask you now about that service. The service is now an internationally leading statewide specialist service. Can I take you back to 2015 when it was created. What were the circumstances that led to the investment of money that made that service possible?

If you don't mind me going back even further?

Q. Absolutely.

A. That would be probably helpful in setting the scene for it. The Royal Children's Hospital had its first transgender patient present for care in 2003, the second patient presented in 2005, and the third in 2007, so it's fairly recent in terms of medical care for the Children's Hospital.

I joined the service in 2012, and that year we had 18 referrals, so still a very low number. What was happening at that time was that there were a number of individual clinicians who were seeing patients within their overall practice, fitting them into their clinics and providing the care that was required, and that was fine when the numbers were low and it was fairly easy to manage.

 Between 2012 and 2014 there was an exponential rise in referrals, and in 2014 we had 104 new patients, which obviously overloaded these clinicians, and it wasn't possible to see them all in a timely manner. Actually, what happened in a short period of time is that the waiting list blew out to 14 months.

And we know that the time on the waiting list is a dangerous time, because in terms of risk of suicide the highest time of risk is the time between coming out, as Commissioner Allen was saying, but also the time which is kind of related to that, is when a person decides that they want to seek care and actually time that they can access care. So, having a long waiting list is literally a killer and it's also one of those entities which you can't define because you don't know the people that are on that waiting list.

So, for me, being responsible for the adolescent medicine team, and we held the responsibility for what was the gender service as such, was that, I felt that the risk was too great and the responsibility I wasn't comfortable with in certainly going about things the same way.

- Q. Do you mean, the risk of suicide amongst young people who were waiting to get in?
- A. On the waiting list, that's right. Because we hadn't met these young people before, we didn't know who they were, what their level of risk was, but we knew it was going to be high.

So, with the support of the Executive of the Royal

Children's Hospital, we approached the government at the time to ask for some help to make sure that these young people were looked after and were safe. And at this stage it was 2014 and there was a state election that year, and so, we met with the government of the time and we also met with the opposition.

And what has been really interesting for me was that, about two weeks before the election Four Corners did a story called, Being Me, and Being Me featured two highly intelligent articulate young trans girls, Georgie Stone and Isabelle Langley, and they talked about their stories and their families and they also talked about how the Royal Children's Hospital had helped them and how they were doing well because of the support that they'd received.

And, as I think you've probably seen with this Royal Commission, it's the personal stories that make the difference, that make things make sense. And, following the election, we had the Labor Government come into power and we worked closely with them to then get a funded service up and running. And, from the beginning, I have to say, they have been extraordinarily supportive. I mean, it helps having a Minister for Equality and a Minister for Mental Health who has come in being very well informed on the issues at hand.

There was an announcement that the gender service would receive \$6 million over four years to establish itself as a service. And, with that money, because we had no structure in place, it was a really good opportunity to actually put together an efficient evidence-based service right from the start.

So what I did was, I hired 12 part-time staff: so we had paediatricians, psychologists, child and adolescent psychiatrists, and some gynaecological support and also included in that team was a clinical nurse consultant and others, and we've been able to produce outcomes over the four years which has, as you mentioned, led to international acclaim and, if I may indulge myself, we have been written up in The Lancet as a world-leading service for children and adolescents who identify as trans and gender diverse.

Q. Can I ask you about the multidisciplinary and integrated nature of your service: how that works and why

it's important that it has those two features? Yes. So, multidisciplinary integrated care really is a system of care that brings together disciplines across medical mental health and allied health specialities. when you bring together that expertise in a co-located environment, you can create a team that is there to primarily support that young person at the centre, their family and their extended support networks.

 So, how that might work in a practical context with the Royal Children's Hospital is, if I use the example of a 10-year-old who comes to see us. We run an initial triage assessment. Once we receive the referral, that's done by a clinical nurse consultant or a junior doctor, and that's really to assess the level of risk, as well as to provide support and education to that young person and their family, and we also link them into community-based support so that we know that, whilst they're waiting for further care they can access what they need in the community: sort of primary care and across community-based mental health services.

We also then allocate them a paediatrician and a mental health clinician. So, that mental health clinician may be a child and adolescent psychiatrist or it may be a psychologist, and the paediatrician and the mental health clinician form the base of that multidisciplinary team and they make decisions together along with that child and the family.

And why this works, is that - and I should add, sorry, that although we have the core paediatrician and mental health clinician as the base of that team, we also have subspecialty expertise with gynaecology, with speech pathology, with others that we can bring in as required over the life course of that person's care at the Children's.

And why I think it works, why it's been acclaimed as a way that we've been able to achieve good outcomes, is because the co-location and the multidisciplinary nature allows really efficient and effective communication; it provides a safe place for families to ask questions and to make plans with us collaboratively.

It also, I guess, in terms of that emotional safety, they have a home, they know where to come if they have any

problems and they know how we can be contacted as things arise and we can be flexible within that team.

Q. Is there a misconception in some parts that the role of the mental health clinician is to diagnose gender dysphoria?

A. Yeah, it's really interesting when we think about mental health clinicians within the context of trans and gender diverse children, because you don't really need someone to diagnose a person with gender dysphoria, because a trans identity is something that's so innately personal that really only that young person or adult, depending on what time of their life they're coming in, only they know how they feel about their gender and whether that's a problem or not for them.

The mental health clinicians really have a role in managing the consequences of that person's experiences when they're living as a trans person, or trying to help them understand some of the feelings that they may have and their fears and anxieties, as well as the - obviously, we manage risk and so forth.

But I think what's really important to note as well, is that, it's not just the mental health clinicians within our team that are there to support mental health, because for trans and gender diverse children it's actually the medical interventions as well as some surgical interventions that help their mental health.

So, for young people they often say, "I don't need to talk about this any more, I just actually need to transition", or for someone who might be 12 or 13, "My emerging puberty is causing me so much distress", that the only way to manage that distress and the consequences that come from that distress is actually to have the physical interventions from the paediatricians with puberty blockers.

So, as a team, it's not just the mental health clinicians that are responsible and are effective in improving someone's mental health, but it actually takes all of us. So, from the paediatricians, our clinical nurse consultant, our speech pathologist, everybody has the primary goal of working to help that young person be who they are and, in that way, improving and maximising their mental health.

Q. What are the trends in the demands for the service at the Royal Children's Hospital?

A. Yeah, so if we go back then to 2014, it has continued to increase exponentially, and that's not just because of who we are and that we've got a service that's accessible, but it's a phenomena that is consistent across western societies. As trans people have become more visible, and as expressing one's trans identity has become more socially acceptable, what we've seen are large numbers of people coming forward.

So, the graph which is included in my submission shows this rapid rise. Last year we had 269 new referrals, and we've just done the figures for 2019 for the first six months of the year, and that's 20 per cent above last year's number, so it's likely that we'll be receiving over 300 new referrals this year.

And when you think that we're a statewide service, we're the only specialist service for trans and gender diverse children and adolescents in Victoria, we don't treat these young people for a short time, we keep them and look after them and care for them usually until they finish Year 12 when they can be transitioned into adult care, so our numbers increase accumulatively as the years pass.

Q. And the costs of providing that kind of care are high, aren't they?

A. They are high, and if you think back to that number of new referrals, 104 in 2014 when we were negotiating with government about funding for the gender service: we've now had a 300 per cent increase based on the figures for this year, a 250 per cent increase if you look at the numbers from 2018, so we're trying to do the same care with three times the number of young people, and it's actually more than that because of the accumulation of patients over time.

- Q. And the same funding?
- A. Yes, the same funding. So, our four years of funding actually ran out two and a half weeks ago on 30 June, and we're currently working with the Department of Health and Human Services on how it's going to be funded from here.

I'm confident that the Victorian Government have a really good understanding of what the needs of this

population are, and I know that they're very keen to continue to see good outcomes and that they know the pressures that we're under at the Royal Children's Hospital in terms of numbers.

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They're also aware that what we've seen is that we've continued to do the triaging assessment not long after young people are referred, so we're seeing them quite quickly, but what's happening now is that the time between that point and seeing the paediatricians and the psychiatrists and so forth is stretching further and further apart.

So, whilst we're doing our best to stay on top of it, it's a constant challenge and we haven't seen any increase in funding and I'm hoping that that will come.

 I think, with a service like this, where you have a uniquely vulnerable population, there's always going to be a need to look at care in a complex way and to do what you can to get good outcomes, and essentially save lives.

From a department perspective or what have you, I think there's always going to be a risk that they will want to fit you into existing funding mechanisms, and this is something that - a risk that we carry and an anxiety that we carry because of the politicisation of trans health and trans children in particular, that with changes in government we might end up having to really struggle to find that funding.

What's really clear to us is that activity-based funding, or the current systems that are often used to allocate funding, really don't cover the cost of providing good care for this vulnerable group. And it's because activity-based funding is really based on the face-to-face interactions at the hospital with the young person and the clinicians, but we do more than that when we are providing great care, because the problem itself is not actually the child in front of us; the problem is their environment that they're often living in.

So, we don't just focus on the child, we are focusing on the child, their parents, which may be mum and dad, it might be a stepmum, a step-dad, the siblings, the grandparents, schools. We also have to work with other care providers such as foster carers, carers in residential

units or elsewhere to make sure that we're providing comprehensive and holistic care, and none of that is covered in activity-based funding. The calculations that we've done at the Children's suggests that only a third of our costs would be covered, and obviously our waiting lists would blow out if our staffing was reduced by that much.

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- How do young people without supportive families get access to a service like yours?
- Yeah, well, we see that's a good point, because we only see young people that have at least one parent who's supportive, because to come to a specialist service you need to get a referral from a GP, and then come in to the Royal Children's Hospital. So, most kids need a parent to assist them with that.

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I have to say, we have had a couple of young people who are highly resilient, very resourceful who have managed to do it on their own, but it's pretty rare. So, there is a whole population, I suspect, of young people who aren't able to access our service because they don't have that family support, and I think that's where the school system is really important in looking after these children and adolescents, but we don't know who they are and we can't measure them, so it's very much an unknown.

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We've asked you some questions about what changes you'd like to see systematically to the mental health system to better address the mental health needs of trans gendered young people. You've already mentioned secure long-term funding for specialist multidisciplinary integrated gender services, and we've probably covered that one.

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Α. I did.

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- And you've emphasised secure and long-term. Ο.
- Α. Yes, thank you.

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- 39 Are there other aspects of systematic reform that you would like to emphasise? 40
 - Yeah. I think, when we're talking about the most vulnerable, they're the ones without the family support, without the parents that can bring them in, and we've seen great success with Safe Schools and also with the Doctors in Secondary School Program, which my team has been involved in, in terms of providing secondary advice and education.

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I feel that, if we could extend and build on the success of Safe Schools and the Doctors in Secondary Schools Programs and put mental health clinicians within schools, then that would provide a great resource for young people who don't feel supported at home.

There has been some of this work starting with some psychologists in schools actually being recently implemented by government, but I really think that it would be worthwhile to extend it out.

And existing services that are community-based tend not to be connected to the other services. So, for example, if we take community-based psychologists and so forth, when you're a statewide service and you're dealing with psychologists across the state, trying to communicate patient information and treatment plans and so forth with lots of different people can be really inefficient.

But because we're dealing with the schools often anyway, and supporting that young person in schools, if we had the mental health support in the school as well, it would just provide, I think, a better more well-rounded level of support for each of these young people.

So there's the school level, there's the primary health care level, which I think Dr McNair has described very well, and then there's the next level which is the specialist services, which I won't go into because we have, as you've explained.

But we need to have the support at all of those levels and, taking it a step further, I think integrating with the adult gender services as well and ensuring that transition is happening so that people aren't falling through the cracks.

- Q. Just on that point: is transitioning occurring well or at all between the child and adolescent and the adult services for trans and gender diverse people receiving your kind of care?
- A. Yeah, we're very lucky in Victoria because we've got fantastic specialist GP practices like Northside Clinic and Equinox, and Prahran Market Clinic as well. Because most of our young people have gone through a multidisciplinary assessment and care, by the time we transition them into

adult services, usually after they've finished VCE or once they turn 18, around that time, they often don't need specialist care through the Monash Gender Clinic, they just need good general practitioners who can continue on with that level of support and hormone prescribing.

We do have some young people that have severe mental health impairment who do need specialist mental health psychiatrists to be involved, but they're usually the minority actually. And, we've developed really strong relationships with both the Monash Gender Clinic and the specialist GP practices, and we develop relationships with young people's GPs, their family doctors that they've been with for a long time, over the time period that we've looked after them. I'm often very pleasantly surprised with how many GPs wish to take on the care and have learnt through the communication with us what to do and feel confident to carry on with that care.

Q. Thank you. Dr Telfer, is there anything that I've missed out that you really wanted to say?

A. I guess, just as a final comment, I do understand that this is a very supportive environment here today: I think trans children are often demonised and vilified in the media, and we all have probably seen how brutal that can be for them.

But I just want to say that, there is absolutely nothing to fear from supporting trans children. Trans children don't come with a political agenda, they just are being themselves, and I think what is ultimately what these children and adolescents want is what all children and adolescents want, which is to feel love unconditionally by their families, to go to school and do well and have friends, to go to TAFE or university and get a job and have relationships and have their own family. Often that really basic message around, just want to have a safe, normal, happy life, is lost with all the noise that's often generated more widely.

MS NICHOLS: Thank you very much. Chair, are there any questions for Professor Telfer?

CHAIR: Yes, Professor McSherry.

COMMISSIONER McSHERRY: Q. Thank you very much, Associate Professor. Just one question from me. You've

mentioned in your statement a bit about the tyranny of distance, those living in rural and regional areas. But you've mentioned shared care: could you perhaps tell us a little bit more about that, how that would work for people living in rural or regional areas?

A. Yeah. So, about six years ago there was a nurse consultant up in Wodonga who approached us from a service called Gateway Health. And Wodonga had a number of trans and gender diverse young people who were seeking primary care there, and she said that she'd identified some specialists who were interested in becoming involved with their care.

What we managed to do is to provide some education and training to two paediatricians and a child and adolescent psychiatrist who are based in Wodonga. We developed a shared care model which initially we required - to provide quite a lot of support for these specialists in helping them manage patients, but actually six years on they're doing it on their own, they're highly capable, and these young people from Wodonga, whilst we're aware and sometimes intervene with their care in terms of providing that highly specialised interventions such as fertility preservation procedures, et cetera, they really don't need to come to Melbourne any more and they're receiving their care in Wodonga.

I was only there a couple of weekends ago and seeing some of the young people who I looked after as young children who are now doing really well as older adolescents, and they've been able to set up a wonderful service.

So, I think, if we could do the same in other areas of regional and rural Victoria, we could access these vulnerable children and provide much better care for them.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Q. There's just one other point I'd like to raise, Associate Professor. In the material you gave us and in the attachments it did show the data about the high prevalence of mental health distress and risk. As a result of the interventions through your clinic, have you been able to measure improvements in mental health and wellbeing and reduced risk of harm and suicidality, for example?

A. Yeah. So, Trans 20, which is the longitudinal cohort

study, has generated some preliminary data that we haven't yet published, we're in the process of trying to publish that. But what we've seen in the first year of engagement with the service is that levels of depression and anxiety have decreased significantly, and we've seen improvements in quality of life.

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We've also done some qualitative work around their experiences of accessing the service, and that's been really positive, with the families and the young people themselves expressing an increased sense of agency over their own health, their own identity and their own ability to navigate society and their life in general, with improved levels of confidence, as well as engagement and also their sense of self, which has been very much improved by having the Children's Hospital being involved in their care.

- Q. Thank you very much.
- A. In terms of suicidality, it's probably too early to look at the actual numbers, but I have to say, in the 16 years that the gender service has been in operation, we've seen lots of young people presenting with a history of attempted suicide, but once they're actually in the service and getting the support, it's quite well, it's very uncommon.

I was thinking this morning actually how many young people I'm aware of who have needed to be admitted to an acute mental health facility because of a suicide attempt, and from those who are engaged in our service, I could think of four; which, compared to the Trans Pathways data, where one in two were attempting suicide, it just goes to show how a bit of support can turn people's lives around.

THE CHAIR: Thank you very much.

MS NICHOLS: May Dr Telfer be excused please?

CHAIR: Yes, thank you very much for your evidence today and your statement.

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MS NICHOLS: That concludes the evidence until after lunch.

1 2	LUNCHEON ADJOURNMENT
3	UPON RESUMING AFTER LUNCH
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5	MS COGHLAN: The next witness to be called is Katie
6	Larsen. I call her now.
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8	<pre><katie [2.04pm]<="" affirmed="" and="" examined:="" larsen,="" pre=""></katie></pre>
9	NG GOGTT TITLE OF THE
10	MS COGHLAN: Q. Ms Larsen, you've made a statement with
11	the assistance of lawyers for the Royal Commission?
12	A. Yes.
13	O T touries that statement [MTH 0001 0025 0001] Wassesser
14	Q. I tender that statement. [WIT.0001.0035.0001] You are
15	the General Manager, Diversity, Inclusion and Participation at Mind Australia Limited?
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17 18	A. That's correct.
	O In that wale was average Mindle evernientianel
19	Q. In that role, you oversee Mind's organisational
20	diversity and inclusion, and inclusion strategy, as well as
21 22	its participation and engagement strategies?
	A. That's correct, yes.
23	O In that wale what do you atwisse to achieve?
24	Q. In that role, what do you strive to achieve?
25	A. I strive to achieve a mental health service both as a
26	service provider and as a workplace that considers a
27	response to access and inclusion requirements and needs of
28	marginalised people in communities, as well as
29	understanding how we can centre the voices and experiences
30	of people who have lived experiences, people who benefit
31	from our services in the work that we do and the decisions
32	that we make around service design and delivery.
33 34	Q. I want to ask you about what Mind does, but also about
35	Q. I want to ask you about what Mind does, but also about the Mind Equality Centre. Can I just ask you about Mind to
36	start with, and can you just explain, please, Mind's role
37	in mental health service provision?
38	A. Absolutely. So, Mind is a leading Australian
39	community managed mental health service provider. We have
40	a focus on recovery for people experiencing severe and
41	complex mental illness and mental distress.
42	complex mental lilless and mental discless.
43	So, we operate nationally across Queensland, South
44	Australia, Western Australia and Victoria. In Victoria we
45	have a range of services and supports, including
46	information and advice, support coordination, in home and
47	community care, subacute services and family and carer

1	supports.
	Bupports.

- Q. Then, what about the Mind Equality Centre?
- A. Yes, the Mind Equality Centre is a LGBTIQ+ specialist service. It was developed in 2017 after members of our senior executive group identified that there was both disproportionately high rates of mental illness and mental ill-health amongst LGBTIQ+ people in our communities, and also that there was a lack of specialist services to meet the needs of those communities.

- Q. One of the things you say in your statement is that the Mind Equality Centre provides a range of targeted allied health supports.
- A. Yep.

- Q. Can you just explain that a bit further, please?
- A. Yeah, so essentially we have LGBTIQ+ specialist staff and they provide a range of services, allied health services, through things like individual and family and relationship counselling, suicide prevention and a range of other counselling supports.

- Q. What about the staff who are employed there?
- A. So, the staff that are employed there are LGBTIQ+ specialist staff: so what that means is that they have practised expertise in working with and meeting the needs of LGBTIQ+ people in communities. They may be LGBTQI identified themselves or they would be very strong allies of the community.

Q. In your statement you say that:

"The Equality Centre meets the needs of some of the most vulnerable members of the LGBTIQ+ communities."

Can you just expand on that, particularly in relation to the way in which the Mind Equality Centre provides services?

A. Yeah. So, as has been discussed this morning through the other testimonies, there's a range of factors that contribute to the vulnerabilities that LGBTIQ+ people and communities may experience.

So, we respond to those in terms of how we deliver the practice that we provide, but in addition to that we also -

what we're seeing is a real vulnerability in terms of the people who are seeking that access of a LGBTIQ+ specialist service. So, about 95 per cent of the people that access the Equality Centre do so through the Medicare Benefits Schedule or the MBS, and of that 95 per cent, about 85 per cent are unable to meet the gap payment through various reasons relating to their vulnerability.

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So, that makes it quite challenging for us as a service to be sustainable and to continue, because running a service - and the Equality Centre is funded almost entirely by Mind itself, the larger organisation - is really challenging when not receiving those kinds of gap payments, so there's a real issue of sustainability for us.

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- So what happens in practice? Ο.
- In practice, we cover the gap payment for the most part, yes.

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Can I just ask you this: how does the Mind Equality Centre address barriers to accessing mental health services experienced by members of the LGBTIO+ community, bearing in mind some of the evidence that the Commissioners have already heard today?

Yeah, so I just wanted to touch briefly on, I guess, what we've discussed previously, so the disproportionately high rates of mental ill-health and the interrelated nature of those mental health rates with experiences of stigma, prejudice, discrimination and marginalisation, and the corresponding impact where there can be a real lack of interest in engaging with mainstream health providers or in accessing those services through fears of what's occurred before.

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So, essentially when there's been experiences of discrimination or ignorance within mainstream mental health services, it erodes trust in the mental health system more broadly for LGBTIQ+ people.

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So, what the Equality Centre seeks to do is to provide a space that is culturally safe, it's welcoming, and that's it's culturally safe and welcoming right through the way the service operates. So, it's sort of from the moment where you first have interaction with the service right through your care journey with the service. So, that's about having LGBTIQ+ staff who understand some of those negative experiences and how they might influence someone's engagement with mental health services; it's creating visibly welcoming environments, which is things like rainbow flags but also the publications that are visible, the kinds of posters that are displayed, little messages to people that this is sort of a green light of inclusion space, they can feel comfortable accessing the environment; forms, processes, language all those kinds of factors as

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> No assumption is being made about someone's sex characteristics or gender identity or sexuality and a range of other factors that support that as a welcoming and safe space.

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- What's the importance of ensuring that staff are Ο. experts in LGBTIO+ practice?
- Well, it means that they understand the unique needs that exist for LGBTIQ+ people and communities, particularly where there's increased levels of vulnerability.

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What we know is that a lot of people have experiences with mental health services where they may experience anything from ignorance through to outright discrimination. It makes it very challenging to trust a service and to actually engage with why they're there, which is around mental health support.

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And also, it means that there can be an understanding of where there might be intersections of particular aspects relating to identity and also health. So, for example, people who may be accessing the service that identify as transgender or gender diverse and also have autism spectrum disorder and understanding a little bit about what that means.

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So it's moving beyond sort of a broad line inclusive process into something that really deeply understands the diversity and the challenges and some of the complexities in the LGBTIQ+ communities.

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You say in your statement that the Equality Centre Q. regularly engages with the LGBTIQ+ communities to ensure that it understands their needs. What does that include? It includes a whole range of things. I think we've talked a lot in some of the other testimonies about community, and for a service like the Equality Centre it's important that we're engaged and connected with community

So, that means things like attending in all its forms. conferences and forums and actually sharing our own practice knowledge and learning from other specialist providers to understand their practice experiences; sitting on alliances and boards and committees; and also regularly attending events: things like the midsummer carnival; Pride March, those kinds of things all make a difference both in terms of ensuring that the service is really connected to the needs of the community and also increasing visibility amongst the community that there are really safe spaces that they can look to.

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- The Commissioners have heard today about the Rainbow Tick accreditation; can you just briefly describe what it is, please?
- Sure, so the Rainbow Tick accreditation is essentially So, it's about assisting health a quality framework. services to move from a place of being LGBTIQ+ friendly, which is sort of that space of, we welcome everyone, we respect everyone, to actually deeply understanding what it is to be LGBTIQ+ inclusive, which is systematically looking at how your service operates and meets the needs of the community, and it's actually working proactively rather than responsively: so taking accountability for a health service to step right through from governance through to operations a space that is LGBTIO+ inclusive and that all the systems and processes support that.

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- And, there are six standards that need to be met or built around in order to achieve the accreditation: can you just very briefly identify what they are? Yes, certainly. So, the first one is organisational
- capability: so that's that embedding LGBTIQ+ inclusive practices across systems.

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Workforce development: so how staff and volunteers understand their responsibilities to LGBTIO+ consumers and are trained and able it to deliver appropriate services.

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Consumer participation: which is a particularly important one, which is how LGBTIQ+ consumers and potentially carers are consulted about and participate in the planning, development, review of the service.

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Welcoming an accessible organisation is the fourth one, which really picks up on those kind of physical environment factors as well as information structures,

resources and processes.

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Disclosure and documentation is another key area, and that's actually picking up on the particular, I suppose, sensitivities or concerns of LGBTIQ+ people about how their information is stored and, if they do choose to disclose, around their sex, sexuality or gender identity, that they can be assured that information is kept safely and there are good processes in place around confidentiality.

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Culturally safe and acceptable services: so, that's how services identify, assess, analyse and manage risks to ensure cultural safety of LGBTIQ+ consumers.

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- The Mind Equality Centre achieved the Rainbow Tick accreditation in February 2018?
- Correct.

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- In terms of the process of achieving it, how long did it take?
- It took about 12 months, and that was with pretty intensive work around it. So, we had two primary staff members guiding that process, the practice leader of the Equality Centre at the time and also a quality and practice advisor based at our central office.

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So they attended the HOW2 program which is run by Rainbow Health Victoria, formerly GLHV. So that was four sessions, four workshop days but in between that a range of steps undertaken to start building competency with the Equality Centre and supporting elements of the organisation, and there were reviews of policies, procedures and systems to ensure they complied with Rainbow Tick standards as well as finding where the gaps were within our organisation in that process.

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Being the Equality Centre, being a one service within our larger organisation, that meant that the level of change required at that deeper systematic level would be less than a large organisation doing it for the whole-of-organisation.

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- Can I ask you about that whole-of-organisation: it is the intention that Mind will seek to achieve the Rainbow Tick?
- Α. Yes. 46

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- Why, apart from what you've identified, why is that 1 2 going to be much more difficult to do?
 - I think it's just a more resource-intensive and time-intensive process. Because, the great thing about the Rainbow Tick is, it really doesn't leave any stone unturned around LGBTIQ+ inclusion. So, it asks you to embed change, both culturally and technically across the organisation.

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So, to do that we have an organisation of over 900 staff operating across four states and a range of different models of service that we deliver on also, each with their own processes. So, while we have overarching organisation processes and policies, we also have one specific to the So, it's a process of exploring all of those areas and ensuring that they comply with the Rainbow Tick standards. So, it's a process whereby we have committed a staff member part time to work on that over the next 18 months, we're aiming to have the Rainbow Tick early 2021, and also kind of recognising that there's a resource element more broadly than that, so that particular staff member as well as support from myself and other departments within the organisation. Which will be probably most of our central office functions, I would think, would be involved in some way in supporting that process.

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What sort of financial investment is needed for that? Well, a very conservative estimate, I think, is about \$60,000 which accounts for the staff time of the person appointed to the role, some other resources from my unit and from our quality and practice team, but it doesn't take into account things like paid consumer and carer participation, our executive time and also our organisational functions time: things like IT, payroll, HR and other systems that will need to support the changes.

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- Why is it considered that the Rainbow Tick Ο. accreditation is so important?
- Well, aside from the reputation in the sense that it offers a market to LGBTIQ+ people and communities that it's a safe organisation to respond to, it's a quality assurance, I think.

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It's about, for many LGBTIQ+ people when they're accessing mainstream mental health services, it can be a matter of luck as to whether that is a positive or a negative experience. That luck can be based on a whole range of factors: it might be the staff members you

encounter; it might be your geographical location in terms of understanding an awareness of LGBTIQ+ issues in that area; it might be the buy-in of leadership, that this is a really important function of the organisation; or any other range of factors.

The Rainbow Tick sort of takes all that chance out of it, I think. It works very systematically to provide assurance right across the organisation and it's centred around - it moves beyond goodwill and good intention into really accountability around leadership: it's actually sort of opening your organisation up to be reviewed and considered and how well you're actually meeting all of these elements which the Rainbow Tick guides on in terms of a fully inclusive experience.

- Q. Can I ask you about the challenges facing the mental health system in being inclusive and how you would address that?
- A. Yeah. So, there's sort of four key challenges that I would see in the issues that we were discussing today. First is the lack of funding and prioritising of population-specific mental health services for LGBTIQ+ communities. So, particularly for people who live outside of inner city Melbourne in terms of access to something that really understands the complexity of need that sometimes exists.

So, that spans every aspect of the mental health services, from counselling, to GPs, to bed-based services. One of the things that we've discussed internally at Mind is the lack of specialist services that are particularly looking at bed-based environments for trans and gender diverse people. So, you're looking potentially there at complexity around an environment when someone is living for a short period of time and there needs to be real understanding of issues around sexual safety and risk mitigation and trauma-informed practice which is interrelated with identity. So, we have those process in place, but there's another layer there to ensure that people who are trans and gender diverse are able to access the services and spaces in bed-based environments that aligned with their gender identity and that they're able to do so feeling supported, not only by staff but also by other clients.

I think that's a really key aspect of this discussion,

and it sort of leads into my next point, is that, we have environments that directly meet the mental health needs of people trying to access them. So, while LGBTIQ+ specialist services are absolutely crucial and Commissioner Allen talked about centres of excellence earlier today, and I think that's absolutely spot on in terms of what we're thinking about, we also need to make sure that if people are in acute or inpatient or crisis environments they have access to the best mental health support for the experience that they're having. So, we need to look at that within specialist services and ensure that they're available as long as they do not consistently get addressed in the mainstream environment.

That said, I think we also need to look at the mainstream mental health service environment and I think there's some urgent areas that we need to address in that space, again, so that people can access the mental health services and environments that are most critical for the care that they need.

 I think, to do that, mainstream mental health services really need to better appreciate and respond to the role they have in providing safe and accessible services, and that's across the board in the mental health system. And, if we don't have that in our mainstream mental health system, then I think it's also really important to acknowledge that we're actually failing to meet the needs of some of the most vulnerable people in our communities, and that's LGBTIQ+ people as well as other people from marginalised populations. If we're not meeting the needs of the most vulnerable, then I don't think we're meeting the needs of the communities that we're working in.

 And, whether in LGBTIQ+ specific or mainstream settings, we need to be able to respond to intersectionality and in that I mean, that while it's important that we have population specific responses around LGBTIQ+ people in communities as well as other communities, for example Aboriginal and Torres Strait Islander, and I know CALD communities will be discussed tomorrow, we also need to recognise that people don't exist in isolation in one identity or another. There's a whole range of ways and experiences that make us who we are, and our mental health system actually needs to be able to understand that too.

I think often we have LGBTIQ+ services over here, and

then services for other communities over here, and what happens when someone who's Aboriginal and gay wants to attend to go to a service that's culturally safe? that service currently? That's the question I would ask.

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So, one of the things we're trying, and looking at at Mind, is really a broader notion of cultural safety, and in doing that as well as attending to population-specific responses, actually looking at broader concepts of inclusion and understanding things like unconscious bias and power, and privilege, and equity, and ensuring that in the way that we respond to inclusion, as well as looking at those unique needs of populations, we're also having a broader discussion about how identity intersects with poor mental health outcomes and how that's interrelated with systematic discrimination and oppression, what we've talked about here today.

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And, if I can just make one final point on that area, which is that, I think - and I think this has come through this morning as well - but when we're talking about the mental health service system and specific populations and communities, we're not just talking about mental health We could create the perfect mental health system for LGBTIQ+ communities, which would be fantastic, but unless we're also dealing with systematic issues and individual issues around homophobia, biphobia, transphobia and interphobia, we're still going to see the disproportionate rates of mental ill-health until our communities and our society more broadly is safer for people who are different and sit within these communities, I think we still have a long way to go and I think that the mental health system has a responsibility in also attending to that aspect of the work.

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- Can I just ask you, this will pick up on some of the themes that you've raised: beyond those matters that you've already raised, what else can be done, and this is from a systems point of view, to be more responsive, suitable and inclusive of LGBTIO+ consumers?
- So, one of the things that I think is absolutely critical, and Commissioner Allen referred to earlier today, is voice: the voice of LGBTIQ+ people in the design of services across our leadership structures. We need to have people in decision-making rooms who have lived experience so that we can ensure that those lived experiences are guiding us through the expertise that they provide.

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Look, funding is always likely to come up I imagine, but from a couple of angles: firstly, from looking at LGBTIQ+ specific services and making sure that people can access those environments that best meet their needs from a mental health perspective.

But also that we think about, within mainstream mental health, that we actually have funding provisions for organisations and service providers to actually address meeting the needs of LGBTIQ+ people in communities and other marginalised communities. And that we then have requirements that are built into funding requirements that we are meeting the needs of the most vulnerable people in our communities.

I think we need to consider competencies in workforce. We were just discussing earlier around workforce and actually being out at work in environments like Mind and other organisations: it's relatively new that so many of us can be open about our identity, and also interrelate that with our work, and that's relatively new. So, there's still a long way for us to go into terms of building competency and safety in workforces, and also developing kind of workforce training for mental health providers to make sure we are meeting the needs of LGBTIQ+ people and communities.

When I say that, I think we can have advanced training for complex and high levels of vulnerability, but we need that basic level of consistent practice around inclusion to be operating right across the service system as a mandatory element.

I also would like to say, and I think Dr McNair spoke to it earlier, about looking at competencies in tertiary and other training around LGBTIQ+ inclusion, and also looking at it as part of professional development programs and considering what we could do about a peer workforce relating to LGBTIQ+ lived experience.

I think we could also look at our models of care. have a whole range of models of care that support mental health services. What we don't have is many that build in social determinants of mental health and really understand how identity and discrimination relate with poorer mental health outcomes and we need to be able to have those

conversations in mental health care models as well as conversations about symptoms and treatment and other holistic models that we might use as well.

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And advocacy, as I sort of spoke to earlier, I think it would be wonderful to see the mental health system more broadly consider the role of advocacy for addressing discrimination and its inter-relationship with poorer mental health. So, Safe Schools has been mentioned several times today: I would say that's the starting process in terms of better mental health outcomes. Also addressing where there is discrimination in workplaces and the kinds of conversations that we have in our community and more broadly in our society around LGBTIQ+ experiences because, as we've heard several times, they continue to impact on the mental health of LGBTIQ+ people in communities

MS COGHLAN: Thank you Ms Larsen. Chair, do the Commissioners have any questions?

COMMISSIONER FELS: Ο. I have one short one. of families and carers in this situation, often we've heard in other parts of this inquiry quite a lot about their role, their contribution: slightly less about that today. Is there any reason for that, or is their role a bit less perhaps than in other areas of mental health? Oh, no, I don't think so. I think possibly what this is my own sort of speculation a little bit - possibly what's happened is that we're possibly having discussions in a little bit of a siloed way again. So, we're talking about LGBTIO+ people today so therefore we're talking about LGBTIO+ people, but absolutely families and carers are critical.

I think in the mental health system and in the health system more broadly what we have had is a history of families and carers, particularly where they might be partners or other forms of relationships and queer relationships, not necessarily being acknowledged. So, I think it's an absolutely critical area, both in recognising and not making assumptions about who people are in LGBTIQ+ people's lives, and also thinking about families of choice which, for many people responding to questions and forms like next of kin and those kinds of questions can be challenging, because they might look quite different for people who have families of choice rather than still remaining connected to their family of origin

CHAIR: Q. Thank you very much. I just have one other question I'd like to ask, it's in relation to - and we heard this morning from Commissioner Allen for the need for many LGBTIQ+ people to be hypervigilant, to be aware of the environment in which they are for their own personal safety and wellbeing. In your statement you also talk about the challenge of bed-based services and the need for people to feel both physically and sexually safe.

When you think about that, through this Royal Commission we've heard already about how challenged those environments can be, and when you think about what the design of bed-based services should be into the future - and I'm conscious that Mind itself provides a number of bed-based services, including PARCs - have you got some thoughts of what needs to be built in to really make sure that, where that need is there and someone must access a bed-based service, they are able to feel safe, both physically and sexually?

A. So I won't talk to the actual structures of the buildings, I don't have a strong service delivery background, so I think I would be stepping into a space that I'm not the best person to answer that question, but I would say that there's probably two elements: one is, while we have a broader mainstream system that is regularly not meeting the needs of people who are particularly trans and gender diverse, then we do need to think about LGBTIQ+ specific bed-based environments in the interim where that's not available or, more broadly, then it is really about having probably an advanced level of training as a minimum requirement for staff: not only for staff to be inclusive, but also to think about how they create environments that

are safe by working with the other clients that are

 Q. Thank you. There's one other point I just wanted to take up which is the discussion about the ability to maintain a financially sustainable service. You describe that at the Equality Centre 85 per cent of your clients have a difficulty paying the gap.

potentially accessing the bed-based service, because it's both. So, I think that would be the place to start.

45 A. M'hmm.

Q. I guess we've also heard a lot at this Royal

Commission about whether 10 sessions even on their own are sufficient. What do you find in terms of the work that you do at the Equality Centre about whether those 10 sessions is all that's needed, or how do you supplement that if no-one has a capacity to pay?

A. So again, I won't - I'll take that on notice in terms of how we always supplement that, but from my discussions

with the staff at the Equality Centre, I certainly know

create a barrier, or it creates a difficulty for us in

that the 10 sessions are not enough, and therefore it can

terms of how we allow that person to access the service.

CHAIR:

Thank you. Thank you very much.

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MS COGHLAN: Thank you. May Ms Larsen be excused?

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CHAIR: Yes, thank you very much for your statement and evidence today.

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MS COGHLAN: The next witness I propose to call, their evidence is the subject of a non-publication order, and they will be giving evidence in the name of a pseudonym. Chair, will the terms of that order be read now?

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CHAIR: Yes, thank you.

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Pursuant to the Inquiries Act 2014, the Royal Commission has made an order prohibiting the publication of any information that might identify the next witness.

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A copy of that order has been placed next to the door of the hearing room. Throughout the hearing today the witness will be referred to as the pseudonym "Alex Smith".

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I would like to remind all persons present including the media that any material which will enable the identification of this witness cannot be published.

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43 44 The hearing of Alex Smith's evidence will be limited to those people attending today's hearing. For those watching on the live stream, this portion of the hearing today will not be broadcasted. I ask that the live stream now be cut.

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MS COGHLAN: Thank you, Chair.

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        (Live stream cut.)
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        MS COGHLAN:
                       I call Alex Smith.
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        <ALEX SMITH, affirmed and examined:</pre>
                                                          [2.36pm]
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        MS COGHLAN:
                       Ο.
                            Alex, you've made a statement with the
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         assistance of the Commission staff?
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              Yes.
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        0.
              I tender that statement.
                                         [WIT.0001.0021.0001.]
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              You were born in England and grew up in Western
        Australia?
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              Yes, that's correct.
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        Q.
              You moved to Melbourne in 2004?
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        Α.
              Yes.
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        Ο.
              How old were you then?
              24 - 23, 24, yeah.
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        Α.
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              Can I ask you how you identify?
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        Ο.
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              I now identify as a trans masculine person, so I've
        medically transitioned, was assigned female at birth.
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              There has been, over the course of particularly your
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         20s, sort of a change in how you have identified?
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                    So, when I first moved to Melbourne I identified
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        as a lesbian female, you know. As a small child I probably
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        did identify more as transgender, but yeah, in my 20s I
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        identified as lesbian.
                                 In my later 20s, I identified as a
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        non-binary person, and since I've begun my journey of
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        medical transitioning, I now identify as a trans masculine
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        person and use he/him or they/them pronouns.
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              Can I ask you about your first interaction with the
        Victorian mental health system?
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              Yes, that would have been when I was around 25, I was
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        admitted to an Emergency Department in a large metropolitan
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        hospital. As a result of a self-harming incident I
        required a number of stitches all up my arm, and I had,
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        yeah, not a great experience when I went into the ED
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        Department.
                      They said to me that I was silly and that I
        shouldn't do things like this, and that I was taking up a
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        bed that could otherwise be used for somebody who was sick.
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        And, I wasn't, like, provided with any referrals to the
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So, on your own, after that time you signed up for counselling provided by an LGBT-specific health service? I found that there was a service online that catered mainly to the gay male community at that time, but was prepared to accept female identifying people, and yeah, I accessed that service at that time and had some sessions with them.

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When you first contacted that service, and I'll just read this from your statement and ask you to comment on it, you say:

I think that all of us in the LGBTQI community know that mental health services that cater specifically to our

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"I remember feeling pressure to be performative about how unwell and volatile I was so to increase my chances of getting help."

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Can you just explain that?

community are badly resourced, and that there's always a wait list and that, in order to access care when you need it, you can't take a strengths based approach to how you're 29 feeling, you need to be as vulnerable and, you know, really lay it on thick about how difficult things are for you, 30 which I think - you know, I understand that people - that 31

32 33 34 there's a list and that people need to be triaged into a level of urgency, but I think that the lack of resources create a situation where there's an incentive for people to be performative about how unwell they are because they know

that, if they don't do that, they'll be bumped down to the 36 37 bottom of the waiting list.

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So, for people that are trying to practice resilience and a strength-based approach to their life in an every day situation, that can mean that they're less likely to be able to access services in a timely fashion, which is a shame.

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- You ended up attending around 16 counselling sessions with that service?
- 47 Α. Yes.

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But you found, given the way the structure or the counselling service operated, that it was - you would see different counsellors?

Yeah, my understanding is that the people that I was seeing at the time were people, like, who are Masters students doing their studies at a Uni and were doing a placement with this health service. So, you know, while they were all lovely, caring and compassionate people, they would - like, their placement would end and then you would be, you know, like handed over to a new Masters student who would also be completing their rotation: so there was a lack of continuity of care, perhaps a lack of clinical expertise because they weren't - you know, they were at the beginning of their careers rather than in the middle of them.

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And yeah, I found it really emotionally draining for that to happen and, when one of my counsellors came to the end of their placement I decided not to go back there because I couldn't - yeah, I just didn't feel like I could start again with another person.

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Can I ask you about a period of time in 2010 when you were working as a public servant and you contacted the Employee Assistance Program: can you just tell the Commissioners about that?

Yeah, I was working for a large institution at that time and they, like many organisations, had an Employee Assistance Program that you can call up to make an appointment for counselling. I did that with the service and had a meeting with them and expressed to them that I was having significant difficulties at work because I felt really uncomfortable using the female toilets, and that I didn't wanna use the men's toilets either, and that - yeah, I just felt like it was a really difficult part of my every day and that, you know, I'd be running around to try and find a disabled toilet, which is not ideal either, and the Employee Assistance Program counsellor or psychologist said that that was something that they couldn't help me with, they didn't know anything about that, and they didn't offer me, like, a referral to anywhere else either.

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So, I didn't speak to anybody, like a mental health service or anything like that about my gender-related issues for many years after that because I felt really embarrassed and upset about how that went.

Victoria in 2016, in regional Victoria, a large regional Victorian town. There was a point in time where you felt the need to access services, and so, what did you do about it?

A. Yeah, well, that was a bit of a difficult situation because at that time I identified as non-binary, I was

and then to the Northern Territory, and returned to

Soon after that, you moved to New South Wales for work

A. Yeah, well, that was a bit of a difficult situation because at that time I identified as non-binary, I was going through a process of assisted reproductive treatment with my partner at the time, which was a queer relationship, and I was having a very difficult time at work and in my personal life, so I wanted to access counselling support but I felt that, if I went to anywhere in the country town that I was living in, that, you know, best case scenario they'd be, like, "How curious, tell me about all this stuff", and maybe I would be able to speak to somebody, but I wouldn't be able to speak to anybody who had any, like, knowledge or competency about my life, about my relationship decisions.

And I was worried that, by going to a country-based service and presenting as somebody who was non-binary, that they would consider that in and of itself a part of a mental health concern that I had, and that I would be subject to either, you know, intentional or unintentional stigma and discrimination, so I didn't see anybody in the country town.

I contacted a service in Melbourne which was a couple of hundred Ks away and attempted to get on the wait list for services there. I did the intake process and things like that, and I asked if there was any possibility that I could speak to somebody either after hours when I got home from work, which was about 6 o'clock, and do a telephone-based appointment, or if I could come into Melbourne on a Saturday or a Sunday, because I was working full-time at that time, to see somebody.

Yeah, and it was quite a long time until I was able to access services - this is many, many, many weeks - and yeah, I wasn't able to access the service in a way that worked for me. I had to essentially leave work so that I could speak to the person who was available to talk to me on the telephone: like, I would sit in my car, because it was half an hour to get home and I couldn't - so I just ended up having to do the telephone counselling in my car,

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basically parked next to the train station in this country town, yeah, which wasn't ideal.

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Ο. One of the things you say in your statement is that the telephone counselling you did get was too little, too late, because you had to wait so long.

I was going through the assisted reproductive Yeah. treatment stuff at that time, and I was in a relationship with my partner at that time, and we had to make a really difficult decision around whether or not to continue with IVF treatment or not, and I felt like I was not psychologically stable enough at that point to make a good choice, and I'm not sure that I did make the best choice, and I certainly really hurt my then partner a lot throughout that process by behaving poorly, with a lack of insight, respect, and yeah, I think I was really struggling with gender identity-related issues.

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You know, going through IVF while identifying as a non-binary person is extremely emotionally challenging, and also medically challenging, and not having any psychological support at that time, I think, yeah, really impacted on me and I think it really impacted very detrimentally on my relationship at that time which then came to an end.

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- Can I ask you about March 2018 and getting support to transition and what was available, if any services, at that time?
- So, I had increasingly decided that I wanted to Α. start medically transitioning with hormone replacement therapy, and I was extremely concerned about losing my family through the process, who I have a strained relationship with already. So, I really wanted to access some mental health support, and I was working full-time as I had done throughout this period.

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I called up a LGBTQI service and they let me know that there would be a long wait list. I was referred into a service that didn't have a long wait list, but that I'd have to pay, you know, like the gap payment on a mental health plan, which I was able to do at that time because I was working. That was, yeah, like, really fantastic being able to access a LGBTQI-specific mental health service at that time where I didn't feel like I would have to explain the basics of, you know, what transgender is, what hormone replacement therapy is, what that would mean for somebody's

emotional health or that they would have some competency 1 2 around the basics of trans and gender diverse health care, 3 so yeah, that was good.

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You saw a clinical psychologist at that service? Q. Α. Yes.

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15 16 Ο. And, although you were grateful for that, it wasn't the right fit for you?

The particular counsellor I didn't feel was a great fit for me, because he was a cisgendered male, and at that time, yeah, because of the nature of my transition I felt like it was really difficult to talk to a person with that identity about my body and my life, and it just felt really uncomfortable and it made it harder for me to disclose things that would probably be useful to disclose while accessing mental health support.

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But I was very much aware that, you know, he was really one of the only available people in Victoria who I felt would understand the basics of my situation and was also one of the only people that was able to write what I call the WPATH letters, which is the letters that you need to get gender-affirming surgery, so I wanted to stick with that person for that reason.

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Ultimately, you stopped seeing that psychologist, in part, because you couldn't afford to continue? So, once I made the decision for hormone replacement therapy I also wanted to have chest surgery, which is very expensive, it's not available under Medicare, it's classed as elective cosmetic surgery, and it costs about \$10,500 to have that surgery, so I didn't feel that I could pay for mental health support with that counsellor while saving for surgery because it was obviously quite expensive.

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You talked about some telephone counselling that you had previously. You ended up reconnecting with that service for the purposes of having some counselling with your partner.

Yes. I was having an extremely difficult time. 42 think that within the first year, certainly within the 43 first six months of your decision to transition and to come 44 45 out to, you know, your entire extended workforce, community, friends, friends of friends, and your family, 46 it's extremely - for me it was an extremely difficult time 47

and I ended my relationship with my immediate family except for my mother, so it was a very difficult time and that had a really big impact on my relationship with my new partner.

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> I mean, she, to be honest, was basically doing all the mental health care work for me, which wasn't good for her and it wasn't good for our relationship. So, we really wanted to access - she really wanted to access relationship counselling and I really didn't wanna go to, like, a mainstream couples counsellor, because I just felt like I didn't wanna have to talk to that person about what being trans meant on top of having to have a really awkward interaction about my relationship.

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So, I wanted to go back to the LGBTQI-specific service, but yeah, it took an extremely, extremely long time to get to see a counsellor and yeah, again, it was very much that process that you have to call up - and my partner was calling up, you know, crying on the telephone asking when we're gonna get to see somebody. really worried that our relationship was going to come to an end and that, you know, like, if it was going to, at least we could talk through things first. Yeah, so it was really a very, very difficult time for me and I think I probably did the most acute part of the transition, like, the first three months in the workforce without any mental health care support.

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Eventually, you were connected as a couple with a counsellor, but that turned out to be the same person who had previously provided you individual telephone counselling.

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Yes, that's right. That person was somebody who was part of the LGBTQI community and identified as gender diverse, so I think it was felt by the service that they would be a good fit.

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For us, I don't think that they were the best fit. think, like, it's hard for anybody to find a counsellor or a psychologist that is a good fit and I think that, when you're trying to find a good fit in an extremely - you know, in a very - you know, with a service that has no resources, and that there are hardly any people around, you kind of don't really get heaps of choice, and that, if you decide to stop seeing somebody, you know that that's gonna mean that you're gonna be on a wait list for, you know, three to six months somewhere else, so I decided to stick

with that person for some time, and we definitely made the best of it.

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0. Can I ask you about some privacy concerns you had around that time and you say this in your statement:

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"At the time when my partner and I were accessing couples counselling it dawned on me that a lot of my workplace colleagues were friends or had professional relationships with my couples counsellor and individual counsellor."

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So, that was a realisation you had at that time? I think the LGBTIQ service sector is a small sector, everybody knows each other or, you know, has professional relationships in one way or another, and I think that it is hard to access appropriate, inclusive, specialist mental health support without, yeah, feeling very much like your privacy might be compromised.

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And yeah, I became worried about, you know, how many people for example would have access to my clinical file, what the processes were around whether there would be an alert if somebody else accessed my file, where the file was kept: yeah, I became really worried that just sort of anybody could read my case history if they wanted to. you know, that stuff I don't feel was particularly well set out, so yeah, I decided that that was becoming more of a barrier to me than of benefit at that point.

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You later on decided to seek assistance through the private system?

Yes, I decided that - you know, because I was concerned about the close-knit nature of the LGBTIQ mental health system, that it would just be better for me to go to somebody else that might not know anything about trans or gender diverse issues, or at least didn't know anyone that I knew and wasn't gonna talk to anybody about my life and, you know, the person that I did see who was recommended through an acquaintance was really good, but like, when it came to the end of the session, they let me know that you couldn't use a mental health care plan for that kind of therapy, and so, yeah, I had to pay I think it was like \$145 for the session, which, you know, under other circumstances I probably would have had the capacity to pay because I do work full-time, but I've just been through

chest surgery which, as I mentioned, is very costly, and I also had to take a significant amount of time off work, so I just couldn't afford to pay for that because I'm already trying to pay off debt related to my medical transition. So, yeah, that's what happened with that.

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- Can you tell the Commissioners about your experience with online counselling services?
- Yeah, I think that online counselling services is a really good idea. It's just that, the two times that I attempted to access them, I couldn't get through to Like, I had - yeah, it was on my telephone and you would just wait to connect to a counsellor to join the chatroom or whatever it is, and yeah, nobody connected. So, like on neither of those occasions was I able to get any support, which I actually think would have been a pretty good fit for me because, you know, I have a concern about my privacy, so the idea of being able to access an anonymous service would have been good. And I do think they're good, I just couldn't access it.

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You refer in your statement to accessing online peer support via a Facebook group: can you just talk about that? Yeah. So, a transgender and gender diverse organisation in Victoria runs a really, like, wonderful online Facebook group called The Shed, which is for trans masculine people, people assigned female at birth who are non-binary or transitioning to a male identity. an amazingly important resource for me.

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It was so encouraging to see people that looked like me that were going through the same dilemmas, were having the same weird and at times humorous things happen. know, to see photos that people would generously share of their, like, chest surgery for example; people talking about the cost of health care and different private health insurance companies and how to access gender affirming care under them.

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I really couldn't have continued with work, I think, without having that online Facebook group. I was a bit of a, like, lurker on that group: I didn't really spend much time posting on it or asking questions, but just to be able to see people going through the same thing was of immense personal support to me, and knowing that there was somebody at the trans and gender diverse organisation that was volunteering their time to moderate it and to make it work,

yeah, I was immensely grateful for.

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I hope that one day people like that can be given the resources and support and recognition that they deserve, because they really are saving people's lives and they're saving people's careers and relationships, so that was incredibly important.

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- Can I ask you about the recommendations that you would 0. make to improve the mental health system starting with a publicly accessible database?
- I think that, if there was a database of some kind, or even one that I could access through a referral, that clearly stated that there were a bunch of different mental health practitioners in different areas who had either done LGBTIQ-inclusive training, including trans awareness training, that would be immensely helpful.

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Because, you know, at the moment you're extremely reliant upon, I quess, word-of-mouth. Particularly in rural and regional areas, I'm just not sure that such a thing does exist, but if there was a resource that was created where there would be gaps, then at least we could start to address those gaps and ask people to opt in and maybe ask them if they wanted to undergo training and become a specialist or, you know, an advocate for further services in their area.

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Just picking up something you raised about trans awareness training: you see that as particularly important as compared with having just an awareness of a gay or lesbian client.

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Yeah, I mean, I think that an awareness of gay, lesbian and bisexual issues is extremely important as well, because obviously trans and gender diverse people have all different kinds of sexualities, but I do think that it's fair to say that there's probably less stigma and discrimination and a greater awareness and appreciation of the contributions of gay and lesbian and bisexual people.

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I think that there's still a very low level of awareness or understanding of trans and gender diverse issues, and I think that it's the kind of issue that most many, if not most, general practitioners and mental health practitioners think, I don't know how to deal with that and I'm scared of getting it wrong so I don't wanna try. so, I think that any inclusive practice training program

needs to focus on trans and gender diverse issues because we have different issues.

For example, if you do decide to access hormones, you know, going through a second puberty as I did is a pretty specific situation that comes with its own mental health challenges. You know, the grief around parental and familial rejection around trans and gender diverse identity is quite specific; having some knowledge about surgery, desire for surgery, and an awareness of the fact that there isn't, like, publicly accessible surgery available and the dilemma that that puts people in.

Certainly, the lack of access to bottom surgery in Australia: there's only one surgeon that provides that kind of surgery and it costs, you know, almost \$100,000. So, having people that understand and that you don't have to educate about those issues and that that's the struggle that you're carrying with you when you come in to see somebody, would be really helpful.

Q. One of the themes that you've mentioned in your evidence is about privacy management, and you would like to see more professional practices around the protection of privacy. Can I move on to ask you about the number of mental health sessions provided under a mental health plan? A. Yes. Well, my understanding is that you get your six initial sessions and you can go back to get an additional four sessions if you speak to your GP about it.

So, for me as a trans and gender diverse person, the idea that you could have 10 sessions and be sorted with your transition is absurd. You know, really I think that most people going through, particularly that first year of transitioning, should be I think entitled to one-on-one counselling support at least fortnightly I would have thought, and you would exhaust your entitlements under the Medicare scheme within two and a half months if that was the case.

I think particularly because there's a current legal requirement for you to engage with a clinical psychiatrist or psychologist in order to get the WPATH letters so that you could undergo affirming surgery such as the chest surgery that I had, I think it should be an obligation that, if government is putting that requirement in front of us, then I believe that we should be entitled to accessing

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free or low cost mental health support so that we can actually get those letters so that we can engage with medical practitioners to get the gender-affirming surgeries that we need.

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- Just finally, can I ask you about peer support services?
- Yeah, so the peer support service that I suppose I informally had a relationship with was The Shed which I mentioned, which was the Facebook group. They also do, like, they organise camps and have meetings and things like that, and they're an absolutely crucial part of the - maybe not a formal part of the mental health system, but it should be, and the fact of the matter is that at the moment most of those people that do that kind of work are doing it on a volunteer basis, often who have been through incredible struggles in their own life and know how difficult it is, and so want to volunteer their time to support people in the same situation as them.

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I think that those community organisations should be resourced and that, whether that's financial resources so that they can be paid for the work they do, or whether it's so they can access mental health care support, because certainly sometimes people in those roles are the first responders to an acute - you know, disclosures, mental health crises, disclosures around difficult sexual assaults and things like that, all the difficult things that people go through in life, and particularly for trans and gender diverse people that may be struggling with their identity, people like that are absolutely diamonds that volunteer their time to look after other people, and I think that they should be given access to mental health care support as well while they're doing that kind of peer support.

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MS COGHLAN: Thank you Alex. Chair, do the Commissioners have any questions?

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Thank you very much, Alex, CHAIR: 0. I just have one. for your material today and for being so willing to share with us your journey in your statement.

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You made a point in your statement that reminds us of the need to think about who we need to educate and inform about transgender issues, because you said at one point in your journey you were refused service by a pharmacist in central Melbourne as they did not wish to provide HRT.

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45 46 47 sure that discriminatory practices aren't there, I think that was a very important reminder for us, so that's a broader group of people. Do you want to add anything to that? Yes, I was listening to Dr Telfer's wonderful evidence

When you're thinking about this inclusive program of making

about the youth-based service, and it really did bring a tear to my eye to think about how much of a difference that would have made to somebody like me if there were, like, an adult version of that where you could go somewhere and see a psychologist, where you could get your HRT prescription somewhere that you knew was gonna be safe and inclusive. It would make such a difference to have allied health services and pharmacy services under one roof, or at least under a few roofs that we all knew about.

At the moment there's nothing like that: you look on a Facebook group like The Shed and ask people, you know, "Have you been to a pharmacist and, if so, how were you treated?" And you try and follow the good tip, but it's always dependent on who's working at the front counter.

Yeah, it was incredibly difficult for me getting my first script of HRT, it was incredibly upsetting to be refused service. It was absolutely humiliating, it happened about a hundred metres away from my workplace. had to go back into work, I didn't know what to do, I didn't know where to go. Yeah, it was absolutely humiliating, so yeah, if we could have a kind of multidisciplinary approach to care, that would be an amazing improvement on the current situation.

Thank you very much, Alex, and again, thank you for having the courage to come and share with us today, it's been very helpful.

Thank you. May Alex be excused, please? MS COGHLAN:

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Yes, please.

Thank you, Chair, and Commissioners, that MS COGHLAN: concludes the evidence for today.

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AT 3.15PM THE COMMISSION WAS ADJOURNED TO

CHAIR:

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THURSDAY, 18 JULY 2019 AT 10.00AM
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