# 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


*Transcript produced by Epiq*

1 MS NICHOLS: Good morning, Commissioners. The Royal
2 Commission's terms of reference directs this Commission to
3 inquire specifically into how to improve the mental health
4 of those at greatest risk of experiencing poor mental
5 health outcomes.
6
7 Today we will focus on mental health outcomes in the
8 LGBTQI community. The term LGBTIQ, or QI, is an inclusive
9 abbreviation to encompass a range of diverse sexualities,
10 genders and sex characteristics. It stands, of course, for
11 lesbian, gay, bisexual, trans and gender diverse, intersex,
12 queer and questioning. The term has evolved itself over
13 time and is viewed and experienced differently by different
14 members of the community. Other terms of course are also
15 used.
16
17 There is great diversity of identities and experiences
18 within and between LGBTQI communities, influenced by age,
19 ethnicity, geographical factors, location, disability,
20 migration experience, socio-economic experience and so on.
21
22 LGBTQI people are part of all other population groups,
23 while also forming a specific marginalised population
24 group.
25
26 Although most LGBTQI Australians live happy, healthy
27 lives, a disproportionate number experience worse health
28 outcomes than their non-LGBTQI peers in a range of areas,
29 specifically mental health and suicidality.
30
31 The disproportionately poor outcomes are found in all
32 age groups amongst LGBTQI people. The mental health of
33 LGBTQI people is amongst the poorest in Australia. LGBTQI
34 people have the highest rate of suicidality among any
35 population in Australia.
36
37 The evidence, as you will hear, is that the elevated
38 risk of mental ill-health and suicidality is not due to
39 sexuality, sex, gender identity in and of themselves, but
40 rather due to discrimination and exclusion as key
41 determinants of mental health. This is sometimes referred
42 to as "minority stress".
43
44 There are other contributors to mental ill-health too.
45 For example, lesbian, gay and bisexual Australians are
46 twice as likely as heterosexual Australians to have no
47 contact with family or no family on whom they can rely for

1 serious problems. Figures are likely to be even higher for
2 trans people. There's a long list of compounding factors
3 like this one.
4
5 Trans and gender diverse young people are a highly
6 vulnerable population with very poor mental health
7 outcomes. A recent study of the mental health of trans
8 young people aged 14-25 living in Australia found that
9 75 per cent had been diagnosed with depression; 80 per cent
10 had reported self-harming; and 45 per cent have attempted
11 suicide.
12
13 These outcomes bespeak insidious discrimination and
14 disadvantage that's completely at odds with the values
15 expressed in this Commission's terms of reference. The
16 fact that these matters are being considered here is one
17 opportunity for Victorians to do a whole lot better than
18 that.
19
20 The mental health system itself must, of course, be a
21 system for all. It must provide the same quality and level
22 of care to all Victorians.
23
24 In today and tomorrow's hearings we will recognise
25 that communities of place, culture and identity must feel
26 safe to seek help and be confident that their needs will be
27 understood and met.
28
29 Tomorrow, we'll be focusing on mental health outcomes
30 in culturally and linguistically diverse communities and on
31 their engagement with the mental health system.
32 Ms Coughlan will say more about that tomorrow morning.
33
34 For the purpose of these hearings over two days there
35 will be a focus on these particular broad groups. We
36 appreciate that there is a multiplicity of issues and also
37 a number of sub-populations that we do not have the
38 opportunity to explicitly address in this round of oral
39 hearings.
40
41 The fact that we will be focussing on these
42 populations and these issues should not be taken as a
43 statement that these are the only issues or the only
44 populations with whom the mental health system must grapple
45 and serve, but we hope that by exposing some of these
46 issues we can inform our thinking more broadly.
47

1 Turning to the witnesses to be called today. First
2 you will hear from Ro Allen, who is Victoria's first Gender
3 and Sexuality Commissioner. Commissioner Allen advocates
4 within government for the rights of LGBTQI Victorians.
5 They will talk about the impact of stigma, abuse and
6 prejudice on the mental health of LGBTQI people and the
7 need for mental health services to provide inclusive care.
8
9 Dr Ruth McNair will talk about her role as a GP at the
10 Northside Clinic which has a particular focus on providing
11 primary care and allied mental health services to the
12 LGBTQI communities in Melbourne's north. She will speak
13 about the most vulnerable members of the community,
14 barriers to accessing mental health services, and the
15 systematic changes that could be implemented to reduce
16 them.
17
18 Associate Professor Michelle Telfer is the Head of the
19 Department of Adolescent Medicine at the Royal Children's
20 Hospital. The Royal Children's Hospital has the leading
21 centre for medical and mental health care for trans and
22 gender diverse young people in Australia. She will address
23 why it is that trans and gender diverse young people
24 experience poorer mental health outcomes compared to the
25 general population and compared to other parts of the
26 LGBTQI community. She will give evidence about the gender
27 service provided at the Royal Children's Hospital.
28
29 Katie Larsen is the General Manager, Diversity,
30 Inclusion and Participation at Mind Australia. She will
31 give evidence about Mind and the Mind Equality Centre, a
32 specialist counselling and support service operated for
33 LGBTQI people. She will talk about Rainbow Tick
34 accreditation which is a quality improvement framework to
35 assist health services to move from being LGBTQI friendly
36 to being inclusive.
37
38 Finally, a consumer witness will be called; they will
39 talk about their experiences as a trans masculine person
40 trying to access appropriate mental health services and how
41 challenging this was. They will be giving evidence using a
42 pseudonym and their evidence will be the subject of a
43 non-publication order which prohibits identifying
44 information from being published.
45
46 I will call the first witness now, Commissioner Ro
47 Allen.

1
2 **<RO ALLEN, sworn and examined: [10.08am]**
3
4 MS NICHOLS: Q. Commissioner Allen, are you Victoria's
5 Commissioner For Gender and Sexuality?
6 A. That's correct.
7
8 Q. Are you the first such Commissioner in Victoria?
9 A. That's absolutely correct.
10
11 Q. And in Australia?
12 A. In Australia as well, yes. Before I start, can I just
13 acknowledge that I give my evidence today on the land of
14 the Wurundjeri people and I pay respects to their Elders
15 past and present and all Aboriginal people, and also just
16 take a moment to remember everyone that we have lost
17 through suicide, and particularly LGBTQI people today and
18 it's in their honour that I give evidence. Thank you.
19
20 Q. Thank you, Commissioner Allen. Have you, with the
21 assistance of the Victorian Government Solicitor, prepared
22 a statement which addresses the questions the Royal
23 Commission has asked of you?
24 A. I have.
25
26 Q. I tender the statement. [WIT.0003.0007.1001] Can I
27 just ask you a question about language before we commence.
28 Is it the case that language used to describe lesbian, gay,
29 bisexual, trans, gender diverse, intersex and queer people,
30 in different parts of those communities, has changed over
31 time and can differ between people and across cultures?
32 A. Absolutely. I think every time we look, the alphabet
33 gets a bit longer, language is evolving. In America, they
34 just use LGBT; in Australia we use I for intersex
35 community. Recently in government we've just added the Q.
36 Sometimes it can be Q and I. There's different variations,
37 but the same community.
38
39 Q. So today, if we use one of those variations we'll both
40 be speaking about the same broad community, if that's
41 alright?
42 A. Yes. Some of the data though does just actually look
43 at different parts of that community. So, if my submission
44 refers to a particular part of the alphabet, it's because
45 that's the bit that's been researched.
46
47 Q. Indeed, and we'll go through that when we look at

1 particular parts of the data.
2
3 In July 2015, you were appointed Victoria's first
4 Commissioner for Gender and Sexuality. What are the core
5 functions of your role and how do you advocate within
6 government for the LGBTQI community?
7 A. The core role is really to make Victoria a safer place
8 for lesbian, gay, bisexual, trans, gender diverse and
9 intersex community. I do that within government, I sit
10 within the Department of Premier and Cabinet which gives me
11 great access to all levels of government. I do things like
12 train LGBTQI 101, I've recently done that with the judicial
13 system, magistrates and judges across Victoria to make sure
14 that when our community is before any judge or magistrate
15 in Victoria that there's a clear understanding of our
16 communities and our families.
17
18 So, anything that can provide education, reduce
19 discrimination and stigma, that can be in the corporate
20 world around how to employ more trans and gender diverse
21 people who are under-employed. It's in sporting
22 facilities, so I get to go out of government and work right
23 across with the AFL and others around sport because there's
24 discrimination in sporting areas as well, and we know that
25 physical health has implications on our mental health.
26 It's a very broad portfolio and I get to work right across
27 many stakeholders in that.
28
29 Q. How does your role consider and respond to issues
30 relating to the mental health of the LGBTQI community?
31 A. Well, I think my fundamental role is to reduce the
32 stigma and educate people, and really, as you said in your
33 introduction, it is not our gender identity, our sexuality
34 or our intersex variation that is the cause of our mental
35 health, it is actually the discrimination that we
36 experience, the isolation, the family rejection that is the
37 cause of that. So, that's my major focus, I'd say.
38 Everything I do is for the betterment of the mental health
39 of the LGBTQI community.
40
41 Q. Can I ask you about the differences between the mental
42 health outcomes of the LGBTQI community and the general
43 population?
44 A. Yeah. We unfortunately, as you said, many of us are
45 doing very, very well, but unfortunately some of us are
46 parts of other high risk groups as well. We know that
47 homelessness is a key factor; many trans and gender diverse

1 folk are homeless due to low unemployment. Certainly, gay
2 men around poverty, poverty's another issue. Many gay men
3 didn't believe they were going to be alive as long as they
4 were so they didn't plan a future in that, so poverty is
5 one of the indicators, and of course we're represented
6 there; as well as homelessness; we're also over-represented
7 in family violence, so we have family violence in our
8 communities, but for our community that includes the
9 violence that's perpetrated upon us by our family members,
10 and so, we know that's another causal or risk factor for
11 mental health.
12
13 I think it's the ongoing minority stress, and you
14 mentioned that as well: that every day knowing that, any
15 time you step out of the door, or even within your own
16 family, you can experience physical or verbal assault or
17 abuse in any way or shape, and that is an enormous level of
18 anxiety that we can carry as community.
19
20 Q. Did the Australian Bureau of Statistics in its 2007
21 national survey of mental health and wellbeing find these
22 things: that 41.4 per cent of gay, lesbian and bisexual
23 people over the age of 16 had reported symptoms that met
24 the criteria for a mental disorder in the previous 12
25 months, compared to 19.6 per cent of heterosexual people of
26 that age grouping?
27 A. That's absolutely right.
28
29 Q. Did the survey also put that for anxiety, 35 per cent
30 of gay, lesbian, bisexual respondents reported an anxiety
31 disorder compared with 14.1 per cent of their heterosexual
32 counterparts?
33 A. That's absolutely right.
34
35 Q. Did the same study report that for effective
36 disorders, 19.2 per cent of gay, lesbian and bisexual
37 respondents reported an effective disorder compared with
38 6 per cent of their heterosexual counterparts?
39 A. That's correct.
40
41 Q. Does research conducted by the national LGBTI Health
42 Alliance in 2016 also show that, compared with the general
43 population, LGBTQI people of 16 years of age and over are
44 nearly three times more likely to be diagnosed with
45 depression in their lifetime?
46 A. Yes, that's right.
47

1 Q. Did that also show that trans and gender diverse
2 people, specifically aged over 18, are nearly five times
3 more likely to be diagnosed with depression in their
4 lifetime?
5 A. Yeah, it's a really poor picture.
6
7 Q. Do you see outworkings of these kinds of statistics in
8 your day-to-day work and life?
9 A. Yeah, absolutely. I think that the constant living
10 with the fear of being discriminated against - I mean, my
11 own personal experience of physical harm and violence, it
12 has an accumulative effect - as you've said, minority
13 distress - and we don't always get included in services and
14 mental health services.
15
16 I think it's important to remember that in mental
17 health services, it's only in the 70s did homosexuality
18 come off the DSM as a mental disorder, you know, and so
19 there's that stigma that's attached to that. It was only
20 last year that being trans or gender diverse came off the
21 DSM as a mental disorder.
22
23 Q. What are the implications of that?
24 A. Well, it's the belief, the self-shame that people
25 carry. You know, we don't wake up in the cot hating
26 ourselves, it comes from somewhere, and it's that stigma
27 about how we are labelled and identified, whether it's
28 through the media, whether it's through the recent postal
29 survey which was a tsunami of attacks on our mental health,
30 an actual campaign against our mental health. It comes
31 from those places and we carry that. And obviously LGBTQI
32 people at different levels carry different levels of that
33 depending on their life experience. But it's also the
34 perception of how you may be experienced and not just the
35 reality of that every day.
36
37 Q. I'll ask you more about that in a moment. Can I ask
38 you first, do LGBTQI people have higher rates of
39 suicidality?
40 A. Yes, they do, and I think we have very, very bad data
41 collection around this. I can remember going to funerals
42 of young LGBTI people and families didn't know that they
43 were queer; it certainly wasn't recorded, and for the shame
44 and the stigma related to that. Even if they did know that
45 their son or daughter or child had actually committed
46 suicide because of their gender identity not being
47 recognised or supported in the family, or sexuality, it

1 wasn't recorded. So, I would say that even though we know
2 that statistically the suicide of our community is so high,
3 I would say it's an under-reporting of that as well.
4
5 Also, one of the very high risk periods we know for
6 mental health in our community is just before you come out.
7 So, it may be that family generally don't know that
8 somebody is dealing and grappling with those issues, so
9 very unreported in relation to data as well.
10
11 Q. Can you elaborate on the very high risk period just
12 before people come out?
13 A. Yeah, I can certainly talk about my own experience and
14 others. Before you come out is obviously a very high risk
15 period because you don't really know - it's the fear of
16 family exclusion, potentially if you're trans coming out,
17 it's losing your job, your family, your friends; you could
18 be losing your church, your sports club, all of the
19 connectors and protective factors we have that protect us
20 around suicide.
21
22 I always say that, you know, it's how the first person
23 responds when you come out can set you up in your mental
24 health for the rest of your life, because everybody in the
25 room that's come out and everybody, LGBTI in Australia will
26 remember the first time they came out to someone and
27 they'll remember exactly what that person said, and I think
28 they're really high protective factors for folks.
29
30 It may be the first time that somebody comes out about
31 their gender identity or sexuality is actually within the
32 health service, and so, that's so critical that the very
33 first response they get is a positive one.
34
35 Q. You mean, there may be a conversation with a GP, for
36 example?
37 A. Oh, absolutely. It's so important that every GP has
38 the basic LGBTQI 101 and says and can refer to appropriate
39 places and not to conversion practices, which has been an
40 historic thing that has been obviously very, very
41 detrimental to our community.
42
43 Q. We'll come to that one. Are there particular
44 subgroups that have even worse rates of suicidality, like
45 Aboriginal and Torres Strait Islander young people?
46 A. Yep. This is a very dangerous question because there
47 are so many groups, I may forget. But, of course, all of

1 the other intersectionalities within our community and the
2 combined discrimination and racism for First Nations people
3 that may or may not be accepted within their own
4 communities.
5
6 Within the migrant and new arrival community and
7 refugee community, coming out can still be a very dangerous
8 thing. You can be sent home for conversion practices to
9 the country that you've come from. If you are a student,
10 we have a number of international students who come, feel
11 safer in Australia. Many of the countries they come from,
12 such as Malaysia or other countries, it's actually illegal
13 to be gay in those countries. They find some freedom here
14 in Victoria, the equality state, and so it's very difficult
15 culturally for them on needing to return, and it's a high
16 risk of suicide in those periods leading up to when they're
17 being forced to return home.
18
19 Of course, rural and regional folk, the list goes on
20 in relation to all the different sub-groups. So, rural and
21 regional folk, isolation for service providers and the risk
22 of confidentiality in local communities and not feeling
23 like you can access services because of that.
24
25 People with disabilities who are LGBTI, may have
26 neurodiversity issues as well. For many in the disability
27 sector and world, they aren't even considered being
28 heterosexuality or having any sexuality, let alone anyone
29 with a disability being considered as homosexual or
30 bisexual.
31
32 Bisexual people have a higher rate of stigma and
33 discrimination than heterosexual people. Bisexual people
34 can be, not always, but can be discriminated not only from
35 heterosexual cisgender community, but also within the gay
36 and lesbian community can be very cruel as well.
37
38 I mentioned cisgender there, I might take you to my
39 glossary.
40
41 Q. That was useful, can you?
42 A. As I said, language is ever evolving. Cisgender just
43 refers to somebody who's been allocated female at birth,
44 grows up and is a woman, or allocated male at birth and
45 grows up and is a man. So, just as we have heterosexual
46 and homosexual, we have transgender, gender diverse and
47 cisgender, so that's another factor.

1
2 Q. Can I talk to you about the reasons for the
3 differences in mental health outcomes. We have both
4 mentioned minority stress. In that context is there often
5 reference to the notion of vigilance?
6 A. Yeah.
7
8 Q. Can you say something more about that?
9 A. Certainly for trans and gender diverse folk, if you
10 don't fit within what the community and society understands
11 as gender norms, just going on public transport, you may
12 need to be constantly vigilant. I live with that myself,
13 I'm constantly vigilant about where I am and what I'm doing
14 and always scouring for safety in relation to, just
15 travelling through the world.
16
17 It's not uncommon, it's not uncommon to just have
18 abuse yelled at you as a LGBTQI person from a passing car.
19 In my case, many others, you never know whether that's
20 going to escalate into anything potentially violent.
21
22 Then there's other things that you just live with
23 around access and inclusion in services. The Royal
24 Commission is absolutely fabulous today, you arrived, you
25 were incredibly welcomed, there was very friendly security,
26 very friendly welcoming party, there's crayons and
27 colouring books for kids, tea and coffee room, everything
28 you can imagine. But when I asked for the bathroom, I was
29 directed to male and female bathroom. Now, for me who is
30 gender non-conforming or gender diverse, instantly it
31 raises anxiety. To be honest, I came early because of
32 that, I often turn up early to places.
33
34 I also knew that everybody in the gallery, or some
35 people in the gallery may be LGBTQI and it may be another
36 issue for them, so I was able to make sure that everybody
37 here at the Royal Commission, when they were asked, they
38 send a little WhatsApp message around to all the staff that
39 they wouldn't just direct people and assume that they were
40 male or female, that they would make it accessible and I've
41 got the lights on on the third level.
42
43 It's all of those things that you live with every day.
44 The fact that I know every gender neutral safe toilet in
45 Metropolitan Melbourne and most of rural Victoria is
46 alarming, but that's not an individual thing, that's quite
47 a common experience. In fact, there are apps for safe

1 toilets.
2
3 Again, you talk about the stigma, I hope that's not
4 the media grab that comes today. But, you know,
5 "Commissioner comes early to Royal Commission to scope
6 toilets."
7
8 Q. I think you might have just made it into the media
9 grab anyway.
10 A. Yeah, I've just done that. That's a chance to talk
11 about the media, no reflection on the fabulous media that
12 are here today, but it's how our LGBTQI community is
13 stigmatised around that.
14
15 Q. Can you say a bit more about negative stereotyping as
16 a risk factor for the development of poor mental health
17 outcomes?
18 A. Absolutely. I remember as a youth worker speaking to
19 young people, and the only kind of media or connection to
20 community they would often see, particularly in rural and
21 remote communities, was on television, and they'd get this
22 picture of Mardi Gras, you know, and they'd see a
23 half-naked drag queen, and they think, well, that's not me.
24 But they don't see the 100,000 people that are marching for
25 their rights and their freedoms.
26
27 That's how we are a resilient community. We
28 experience so much discrimination, we come together to
29 celebrate ourselves and identity because the other parts of
30 community haven't always celebrated us, and yet what we get
31 fed back to us are particular images and frantic things
32 about toilets and trans people in toilets and all this
33 other sort of stuff.
34
35 The messaging we get back all the time is that you're
36 perverts, you're deviants, you're paedophiles, all of these
37 misconceptions. And so, as I said, you don't wake up in
38 the cot hating yourself, all this stuff is accumulative and
39 builds to minority stress, and how we develop
40 understandings.
41
42 It also stops us from accessing mental health services
43 because of the sense of not being worthy. The number of
44 Elders in my community that have said, no, no, no,
45 Commissioner just make it better for young people, we've
46 had our time, you know. It's a lovely gesture, but also I
47 know it comes from a place of not feeling worth and

1 valuable, and it's so important that we value our Elders in
2 community because they have experienced enormous levels of
3 discrimination.
4
5 Q. Can I ask you about violence, and does research show
6 that up to 80 per cent of same sex attracted and gender
7 questioning young Australians have experienced assaulting
8 behaviour in public?
9 A. Yes.
10
11 Q. And 20 per cent of that same group have experienced
12 explicit threats; 18 per cent have experienced physical
13 abuse, and 26 per cent have experienced other forms of
14 homophobia?
15 A. That's absolutely correct, and how can that not affect
16 our mental health? Yeah.
17
18 Q. For trans and gender diverse people, are the rates of
19 the experience of violence, whether verbal or physical,
20 particularly high?
21 A. Yes, they are. Yeah, absolutely.
22
23 Q. Does data show that about 30 per cent of that group
24 have been threatened with violence?
25 A. Absolutely, and experienced it, yes.
26
27 Q. What about the question of loss of contact with
28 family? Is the data that rejection by family is higher in
29 LGBTI people than the general population?
30 A. Absolutely, and even the fear of losing family contact
31 is really high, but the reality is that many LGBTI people,
32 at any age, can be rejected by their family. Particularly
33 young people coming out can be rejected, but also older
34 people who may come out later in life can be rejected by
35 their children and be particularly vulnerable, if
36 particularly as an elder they are reliant on their
37 children.
38
39 We had this story not that long ago of an elder put in
40 aged care who had the power - in the kid's power. They put
41 them in aged care as the gender they were assigned at
42 birth, not the gender that they'd be living for the last
43 40 years of their life. So, family can be, you know, the
44 perpetrators of violence against our community as much as
45 the broader community. So, you can get it from all areas.
46
47 I think it's also important to remember that, if you

1 are from a multicultural community or an Aboriginal
2 community, you usually have your family around you and you
3 all travel through and experience racism together. Often
4 if you're an LGBTI person, you may be the only LGBTI person
5 in your family, and so, that can also be an isolating
6 experience as well. So, families can be protective, but
7 they can also be a cause root of our mental health issues.
8
9 Q. I was just about to ask you that. It may sound an
10 obvious proposition, but is family connectedness a strong
11 protective factor against poor mental health outcomes?
12 A. Oh, absolutely. You know, I was very lucky when I
13 came out to my family, I was very, very supported. I have
14 been supported by family right through this role; my mother
15 campaigning enormously through the postal survey, you know,
16 in her nursing home. She'd done the numbers, she said,
17 "We've got it Ro" based on the nursing home, we're alright.
18 Reminding everyone except the people who I think are going
19 to vote "no": thanks, mum.
20
21 You know, those connections that people have with
22 family are so critically important, but there are so, so
23 many people that don't have my experience of family
24 connection. And we create our own families, we create our
25 own families of choice. And, of course, our families not
26 being recognised has been an enormous barrier; the families
27 of choice that we create has only recently been accepted
28 fully in Australia. They all - it all is stigma and
29 discrimination.
30
31 Q. Can I ask you to say a little bit more about the role
32 of language and public discourse. You mentioned the postal
33 survey a couple of times. Is there evidence that there was
34 an increase in hate speech and conduct surrounding the
35 postal survey which, for clarity, was the ABS postal survey
36 to determine whether legislation should be changed to
37 permit same-sex couples to marry?
38 A. Yes. We are now a little bit out of that time-wise,
39 we can actually start to look at some of the data that we
40 knew was happening to our communities.
41
42 We saw an incredible increase in hate speech on social
43 media and in the general community during that period.
44 People will say, look back at history and say it was all
45 sorts of things, but for our community it was just a
46 tsunami of attack on our mental health.
47

1 Switchboard, which is an LGBTQI phone counselling
2 service that I talk about in my evidence, saw an incredible
3 increase during the postal survey period. In fact, we
4 didn't have enough volunteers. Switchboard is run by LGBTI
5 volunteers, so it's peer-led. You will ring up and get an
6 LGBTQI person. We didn't have enough people during the
7 postal survey to be able to equip the phones. We ran extra
8 sessions, emergency sessions, calling up people off the
9 bench that hadn't been counsellors for 20 years. In fact,
10 the woman who started Switchboard came back after 20 years
11 to go through a training session and get back on the phone
12 so that we could try and meet the need. We know we didn't
13 answer every call.
14
15 Q. Why do people call into Switchboard typically?
16 A. Switchboard provides peer support, so really if
17 they're struggling for their mental health, or anything
18 around being LGBTI, life in general, isolated, needing
19 support. A lot of calls come in just before somebody comes
20 out and Switchboard can make referrals, but they're really
21 calling to talk to someone that's like themselves, to hear
22 someone that understands the journey that they're on, and
23 that's why peer support programs for our mental health run
24 by LGBTI organisations governed and run by LGBTI people are
25 so important in the system.
26 Q. Was there preliminary research conducted by the
27 Australia Institute and by the National LGBTI Health
28 Alliance based on a study of close to 10,000 participants
29 following the postal survey which showed that about
30 80 per cent of LGBTQI people and almost 60 per cent of
31 allies - and I'll ask you about what that means in a
32 moment - said they found the marriage equality debate
33 considerably or extremely stressful?
34 A. Absolutely right. I was married three months ago,
35 happiest day of my life. I would give it up in a heartbeat
36 if it meant I could undo the three months of torture and
37 trauma really there was on our community.
38
39 People who have been out for a long time, people who
40 are employed, well to do, feel quite secure in their self
41 and their identity, whose family supports them, talk to me
42 about all sorts of triggers that that period gave, and they
43 were the people that were doing very well. So, it doesn't
44 take much to think about the people in our community who
45 are already vulnerable.
46
47 Many in our community completely switched off their

1 social media during - and I recommended that, but they
2 switched off their support. So, as well as switching off
3 seeing all the negative things, during that period they
4 also switched off from being able to get connections and
5 support.
6
7 Every day you could open the newspaper or turn on the
8 radio, or anything, and hear that you're going to hell.
9 You know, it was a regular event, letter to the editor, the
10 slippery slope argument, all the things that were coming to
11 us.
12
13 I remember for me personally that my partner, now
14 wife, and I thought we'd protect our child for the next
15 three months. That was ridiculously naive because it was
16 everywhere. When you're, as I was, standing in front of a
17 group of people delivering LGBTI training and talking about
18 how important it was, behind me out the window was a plane
19 writing an ginormous "no" in the air. Everybody could see
20 that, there was an awkward uncomfortableness and eventually
21 I turned around.
22
23 But not only did that "no" affect me in a visceral
24 way, I knew that the kids in my kid's school were watching
25 that, all the Rainbow kids in schools all over Melbourne
26 were seeing that, every LGBTI person that was vulnerable
27 was seeing that "no" in the air. You know, you couldn't
28 avoid that, and it attacked my mental health, and I know it
29 affected so many people.
30
31 For me, I have a very, very supportive work
32 environment. My boss is the Minister For Mental Health.
33 He was very clear that I was going to get support and
34 counselling every two weeks during the postal survey. It
35 would not have looked good for the Commissioner for Gender
36 and Sexuality to fall over. But not everybody can afford
37 to do that or has the work environment to be able to do
38 that. I'm very proud of the Victorian Government that made
39 rooms available for all the staff across Victoria to watch
40 the results of the postal survey.
41
42 I mean, the fact that I know where I was and that
43 every LGBTI person in Victoria can tell you exactly where
44 they were at the time that the results were delivered, is a
45 real testimony to the impact that it's had on our lives.
46
47 As well, we're now seeing, 12 months on in the

1 research, that there's another blip in our mental health at
2 the 12-month anniversary: you know, people are thinking we
3 should be still excited, we should all be off getting
4 married, how wonderful, but we saw another increase in
5 phone calls and calls on services at Switchboard in that
6 12-month period. So, I believe it's going to have a
7 generational impact on our community, and may we never have
8 another postal survey that a majority in Australia makes a
9 decision about a minority of any shape or form.
10
11 Q. Can I just return to that same survey: did it also
12 find that LGBTQI respondents said that experiences of
13 verbal and physical assaults in the three months following
14 the announcement of the postal vote more than doubled
15 compared with the six months prior to the announcement?
16 A. Yeah, absolutely. It was an authorising environment
17 for hate speech, and I think, you know, hate speech runs at
18 a level in our community, but it just gave the green light.
19 Again, it's a minority group of people that are so vicious
20 that they would do that and yell out of cars and physically
21 attack people, but it's certainly allowed them to do that.
22
23 We saw an increase of posters and campaigns, in every
24 language, campaigning, talking about how deviant we were,
25 it was in every language in letterboxes all over Victoria;
26 posters that were absolutely horrific that showed us in
27 terrible light. We see them occasionally, but there was
28 certainly an increase during that period which was intense.
29
30 Q. Is work going on to conclude that research or to take
31 it further?
32 A. Yes, there is, yep. And I'm actively involved in a
33 new coalition of universities and the Victorian Police and
34 others in looking at hate speech broadly.
35
36 Q. In relation to that survey which was described as
37 preliminary, will the results or the further work likely to
38 be concluded within the lifetime of this Commission?
39 A. I would need to take that on notice.
40
41 Q. On notice, yes.
42 A. But I would hope so, because I think it's a really
43 clear picture of the impact that that sort of process can
44 have on mental health, so even the preliminary findings are
45 pretty compelling, I believe.
46
47 Q. Alright, and if you do complete that work, I'm sure

1 you'll provide it to us and we'll ask you for it.
2 A. I will.
3
4 Q. Can I turn now to the question of examples of
5 resilience and self-care in LGBTQI communities. Can you
6 speak to us about some powerful examples of resilience?
7 A. I think generally we need to classify our community as
8 one of incredible resilience, and we've done that in a
9 number of ways. I've talked about the celebrations,
10 festivals and events, Mardi Gras, pride marches. We do
11 that as a sign of resilience and coming together as
12 community. Broadly, the community you can just see as
13 flamboyant festivals of fun, but they have a real intent
14 about making sure we come together, we check in on each
15 other.
16
17 During the 80s, through the HIV AIDs epidemic, the
18 Victorian AIDS Council, now Thorne Harbour Health, was
19 developed. That's a great example of resilience where our
20 community came together to fight for our survival, but also
21 fight the stigma that particularly gay men had that lived
22 through the Grim Reaper campaign which was another media
23 campaign really that has left a lifetime - people of my
24 generation will remember the Grim Reaper and that caused
25 enormous stigma for gay men. So, groups like that.
26 Switchboard I've talked about, Queer Space at Drummond
27 Street.
28
29 There are so many peer support groups that have been
30 established by community for community that are really
31 about resilience and support and being with each other.
32
33 Recently it again came out of the postal survey, but
34 social media now, we have a Grateful Rainbow Facebook
35 page which again is around making sure that we focus on
36 resilience and strength and supporting each other, and we
37 focus on gratitude. So, for 60 days after the postal
38 survey leading up to Christmas, which we know is a high
39 point time, because many of our community aren't connected
40 to family, Christmas isn't always joyous, to post one thing
41 that we're grateful for. That's coordinated by community
42 for community.
43
44 Those sort of initiatives outside the structured
45 mental health service go an enormous way to support
46 ourselves and to remind ourselves, if the rest of the world
47 isn't, that we are fabulous, wonderful, worth celebrating

1 and quite resilient.
2
3 Not all members obviously, and we've dived into some
4 of that, have that resilience. And there's some stigma
5 about not being resilient in our community as well.
6
7 Q. Can you say a bit more about the expression "by
8 community, for community"?
9 A. I think in government we call it co-design, but
10 basically what it really means is, nothing about us without
11 us; that everything, health service, mental health service,
12 needs to be designed with us. We learnt that in the Royal
13 Commission on family violence. The projects that are
14 working, are working with our community.
15
16 It's certainly not saying that the only support for
17 our community needs to be from our community, and we
18 certainly - I wouldn't want for a minute to let mainstream
19 mental health services off the hook at all in that. But
20 what the services they design need to be are inclusive and
21 culturally sensitive to LGBTI people. The only way to
22 truly do that is to actually involve LGBTI people in the
23 creation of those services.
24
25 Q. Yes. Can I ask you now a little bit more about access
26 to mental health services. Is it the case that there is
27 evidence about the non-use of crisis supports for fear of
28 discrimination?
29 A. Yeah, absolutely. I think it's absolutely,
30 unfortunately, on the mental health system to prove that
31 they are actually safe. When an LGBTI person goes to any
32 service, they may not disclose in the beginning, and what
33 they're saying is, do you see me? Am I safe? Can I trust
34 you? And they are incredibly unforgiving if they get a
35 poor response in the first place; they're very unlikely to
36 go back to that mental health service. Or even the
37 perception, not even walking into that service, that they
38 will be discriminated against will exclude them from early
39 intervention and they may only go into that service when
40 they're actually a tertiary high end need.
41
42 You have to remember that an example of a gay man I
43 know, his experience of the mental health service was
44 electric shock treatment in his life. He didn't have a
45 mental health issue at all but that was purely done to him
46 by the mental health system because he was homosexual and
47 it was an idea that it was a disorder and he needed to be

1 cured as a therapy. There is no way, the earth would
2 freeze over before this gentleman would go back into a
3 mental health service. You could paint it with rainbows
4 and shower it in glitter, this man's not going to go back
5 into a mental health service. So, it's really about how do
6 we actually make sure that people know that it is safe and
7 that they're not going to be discriminated against in that
8 service, yeah.
9
10 Q. Did recent research undertaken by the Lifeline
11 Research Foundation show that over 71 per cent of LGBTI
12 participants choose against using a crisis support service
13 during their most recent personal or mental health crisis?
14 A. That's absolutely right, and there's all sorts of
15 factors that play in this. People may not want to call up
16 an ambulance because potentially they may believe,
17 perceived or real, that the police will be called. I know
18 that you've heard evidence about the amount of police
19 involvement in mental health cases.
20
21 Unfortunately, our community historically has had a
22 very bad relationship with the Victorian Police. We're
23 working very hard to improve that. We now have LGBTI
24 liaison officers, we have terrific support within the
25 Victorian Police, but again, historic beliefs and
26 understandings about whether you will be supported and
27 discriminated, so even to get into a mental health service
28 if they think there will be police involvement. Their
29 family may not call them as well because of that,
30 particularly if it's a rainbow family and they have poor
31 experience of the police and the system. Or just being
32 discriminated when you arrive at a hospital or health
33 service is so critical.
34
35 Q. Can I ask you whether inpatient settings pose
36 particular risks?
37 A. I think they do, and I think other witnesses will give
38 you evidence around the benefits of the Rainbow Tick. The
39 Rainbow Tick is an accreditation that health services can
40 do. It is so important because it takes you through a
41 whole journey of cultural assessment, cultural change for
42 your organisation.
43
44 Basically what we do in the health service system
45 generally is assume that everybody who presents is
46 cisgender and heterosexual, and it's such a barrier to our
47 service, it's a barrier for our families. It needs to be

1 changed. We've learnt again from the Royal Commission Into
2 Family Violence that we've funded a number of family
3 violence organisations to get the Rainbow Tick and we're
4 starting to see that improved; whether they're a lanyard on
5 a staff person that is a rainbow or trans colours, a badge
6 that's really important. We've recently added the black
7 and the brown onto the rainbow to acknowledge First Peoples
8 and people of colour.
9
10 That is so critical. If I walk into any health
11 service and I see a rainbow, I'm instantly relaxed and I
12 know that's a similar experience for many. It's all the
13 way through. As I've said, if you are misgendered by the
14 receptionist, it's very unlikely that you're going to stay
15 in the waiting room.
16
17 The other thing is that all of the health services can
18 be as inclusive as anything; sometimes it's the other
19 clients that will persecute the discrimination, you know,
20 in an acute hospital setting. So, you can be a Rainbow
21 Tick accredited organisation, every nurse and doctor and
22 orderly can be fabulous, but it's about design and system
23 to make sure that we're kept safe, not only from the system
24 but other patients and people within the system that can
25 lash out against our community.
26
27 Q. Turning to good things in the system, is it the case
28 that in Victoria members of the LGBTQI community can access
29 safe and welcoming spaces?
30 A. Absolutely. I don't want to paint a picture that we
31 can't, we absolutely can. The more services that are
32 getting Rainbow Ticked, the more services that we feel we
33 can access. There are GP trainings that are happening.
34 For mental health obviously a GP is a very first point of
35 call for many in our community, and there are so many very
36 inclusive GPs.
37
38 It's still not uncommon though for LGBTI people to be
39 actually educating GPs in their appointment. I had a
40 recent appointment for a vein on my leg and the doctor
41 wanted to talk about my gender identity and sexuality, and
42 at the end of the session I said, "Who's gonna charge who?"
43 You know, it's not an uncommon experience and, when you're
44 presenting with mental health, you're really vulnerable,
45 the last thing you want to do is explain your pronoun and
46 your family make up, you know, or have any doctor ask you
47 who the biological mother is, or all these kind of really

1 offensive things in a rainbow family that aren't relevant
2 to what you presented about, and so, the onus has to be on
3 the GPs, as I said, with judges and magistrates and
4 everybody else, the onus has to be on the service to be
5 able to present and do the education, and not rely on LGBTI
6 people when they're presenting for care to be doing the
7 education.
8
9 Q. Can I ask you about a recent initiative: can we have
10 the slide, please? [WIT.0003.0007.2000] This slide is
11 entitled, "Faith Based Service Providers." Can you tell
12 the Commissioners what that's about?
13 A. So, what we certainly found in the Royal Commission
14 for family violence, and what I've known instinctly, is
15 that LGBTQI people can feel that accessing a faith-based
16 service is another inhibitor.
17
18 So, churches haven't got a good rap when it comes to
19 LGBTQI people, that's not all churches obviously, and there
20 are many affirming and supportive churches. But many
21 churches have been actively involved in conversion
22 practices. I don't call it conversion therapy because I
23 don't want to give it the weight that it doesn't need, but
24 certainly in Victoria, as in many other states, many of the
25 mental health services, but in this case family violence
26 services, are delivered by faith-based services.
27
28 I know firsthand from delivering services in Kinglake
29 after the fires that LGBTI people, one of the only
30 buildings that was left standing was the Uniting Church and
31 I was working for the Uniting Church and that's where we
32 ran food relief and support. They took their animals to
33 the RSPCA to be fed but they wouldn't come into a church,
34 and that's a life-threatening event in the person's life,
35 because of the perception that if they come into that
36 church they will be discriminated against. So, it wasn't
37 until they found out that a queer was running the food
38 relief and I went out to them that they would come.
39
40 Similar to mental health services: right now in
41 Victoria LGBTQI people know that one of those faith-based
42 services has the right under law to discriminate against
43 us. So, you know, you have to get over the hurdle and
44 stigma of coming out, about having family violence or in
45 this case Royal Commission on mental health, then you have
46 to go to another service that's another barrier to know
47 that you could be discriminated against.

1
2 So, you know, I can't wait, I'm a very impatient
3 Commissioner sometimes, and so, I went to these services
4 and they said, "Of course we wouldn't discriminate", and I
5 said, "Well, how - how can we get that message to Victorian
6 LGBTQI people?" So I was very proud of this piece of work.
7 Ten faith-based organisations, UnitingCare, Anglicare,
8 Jewish Care, all signed up to a pledge to say, you know, we
9 will not discriminate against you. They have the right to,
10 but we will not discriminate against you, and they signed
11 up to that and have placed that on their web pages, in
12 their foyers. You know, VincentCare has gone on, a
13 Catholic organisation, to get Rainbow Tick accredited, and
14 that will make an enormous difference to send that message
15 to community that says, you are welcome here, you have
16 every right to this mental health service, or family
17 violence service, or alcohol and drug service as anybody
18 else and you are going to get fair and equal treatment.
19
20 And I think that's really what we're asking for.
21 We're not asking for special treatment, we're asking for
22 fair and reasonable treatment to live in dignity to access
23 services that unfortunately we need at a higher level.
24
25 Q. Are there any other steps that you would like this
26 Commission to pay attention to that you think are likely to
27 increase the mental health of LGBTQI Victorians?
28 A. I think definitely looking at the system, the whole
29 mental health system, at every point in entry, whether it's
30 at the GP training level, all the way to acute care and how
31 do we make sure that all the letters of the alphabet are
32 seen.
33
34 I think putting an LGBTIQ lens over everything: over,
35 okay, what are we doing for rural and regional people?
36 Let's put an LGBTI lens over that. How are we making sure
37 that gay farmers are supported, gay veterans are supported,
38 all the other priority groups we're in?
39
40 Telehealth, rural and regional folk need to access
41 telehealth, is that available in a culturally sensitive way
42 to LGBTI people? I think that's the real focus, is how do
43 we make the whole system accessible.
44
45 And then how do we let LGBTI people know that we are
46 ready and you will be safe to access this service, I think
47 they're the key points. I think that services run by,

1 delivered for and with LGBTI people are really important
2 because, for some people they're just not gonna access
3 mainstream service; for some people they're only going to
4 ring Switchboard, they're only going to go to Queerspace,
5 they're only going to go to Thorne Harbour. But for others
6 in the community they might want confidentiality. The
7 mainstream services need to be accessible. If you're rural
8 and remote, if you're from a multicultural community or
9 your partners going to one service and you want some
10 confidentiality, or family members, so we need both.
11
12 We still need those specialised services that are
13 LGBTI run and supported, and they need to be centres of
14 excellence that mainstream services can look at, because of
15 course we can't just train one round of health providers
16 and set and forget; we need to continuously train people
17 around ways to be accessible in our community.
18
19 There is a magnitude of things that I think needs to
20 be looked at, but the lens needs to go over, I think, every
21 part of the mental health service system.
22
23 MS NICHOLS: Thank you, Ro Allen. Commissioners, are
24 there any questions?
25
26 COMMISSIONER COCKRAM: Q. Thank you, Commissioner. I'm
27 interested, before you were mentioning about children of
28 rainbow families. I think we've been aware that at times
29 they also experience the stigma and discrimination of the
30 world they live in.
31
32 Are there things that we should be thinking about as
33 the Commission in relation to the children, and are there
34 things that you think that we should be very aware of in
35 relation to the impact?
36 A. I think I'll just tell you a quick story on the
37 children front. You know, I mentioned through the postal
38 survey our children's experience, it was incredible to
39 actually see how much they took in about that. Okay, my
40 daughter's a little different as the kid of the
41 Commissioner, maybe had a little bit more exposure than
42 others, whether we liked it or not.
43
44 You know, she said to me, "Mum, can I write your
45 speech for the rally, the marriage equality rally?" And I
46 said, "Absolutely", and I read the speech, and of course I
47 cried, and I said this sounds like something you want to

1 say. Basically she said, yes, she did, and with the
2 permission of her other mother, she got up in front of
3 thousands at the state library and said, you know,
4 acknowledged the traditional owners of the land and did all
5 that, and said, "It doesn't matter what the postal survey
6 says. I love my family and my family loves me", and
7 thanked everybody for supporting her family and her
8 parents.
9
10 So, yes, it does have an impact on the kids; their
11 relationships or their families being recognised. I
12 mentioned recently we got married. One of the things that
13 she said was, "Now I feel legitimate." That's horrific as
14 a parent to hear that, that she didn't feel - some way,
15 some message that she got from society that she wasn't
16 legitimate in a rainbow family. Now, it was in jest and
17 joking, but it was still there, it's still in her language.
18
19 So I think children of rainbow families need to be
20 recognised and the way to do that is recognise families, in
21 all their forms, in all their shapes. We're
22 over-represented as carers as well, and all the forms of -
23 you know, LGBTI kids often in families get the
24 responsibility of looking after their parents or anyone
25 with a mental issue within families.
26
27 So, recognising our families in all their shapes and
28 forms will have a particular impact to support the mental
29 health of the whole family, but particularly our children -
30 who, can I say, our children are doing incredibly well.
31 Statistically our kids are doing equally as well on mental
32 health and everything else in relation to that as kids in
33 heterosexual families, so I want to make that point really
34 clear.
35
36 Clearly anything that supports the visibility of
37 rainbow families, and I think we know, we talked about
38 language and the visibility, that's so important for kids,
39 to feel seen and supported.
40
41 CHAIR: Thank you, Commissioner. I'd just like to ask one
42 other thing, and thank you very much for your very
43 comprehensive overview.
44
45 Q. I guess, I, like everyone, is very challenged by that
46 data about the suicide rate for members of the community
47 and trying to think about how we respond better, because

1 that's totally unacceptable and it's part of our terms of
2 reference around suicide prevention.
3
4 When you talked about the fact that the point of
5 vulnerability for people when they first come out and the
6 importance of the response of the first person who responds
7 to that, you had mentioned the role of Safe Schools and
8 what you think is a potential they play. Can you just help
9 us to understand how else you think we might improve the
10 way in which the system can help respond to that issue?
11 A. It's a great thing that every state school in Victoria
12 is a safe school. I mean, obviously at different levels,
13 and not every young person - recent research from Minus18,
14 which is an LGBTI youth organisation, showed us that not
15 every young person in Victoria knows that their school is a
16 safe school, and that's a real worry and something that
17 we'll keep addressing.
18
19 So it may be around the doctor or nurse in school
20 program. This is so critically important, that all the
21 doctors, nurses, school chaplains, you know, it's so
22 important that the very first thing they say when somebody
23 comes out is, "Congratulations, how fantastic, how
24 wonderful", and it be a positive thing.
25
26 Certainly, that's what Safe Schools is about, it's
27 just, it's not a curriculum, it's around bullying and
28 harassment. It's really important that people understand
29 the impact of bullying at a young age can have a lifetime
30 impact on a young person as they grow up and around their
31 mental health.
32
33 Safe Schools is really important. Of course, it
34 doesn't carry over into Catholic and independent schools,
35 not that - I mean, there are an enormous, you know, growing
36 number of - not enormous, but Catholic and independent
37 schools that are Safe Schools. I know there's quite a
38 market in Safe Schools material broadly in other states
39 from Victoria, but it's an ongoing thing, we need to make
40 sure that young people know, by language, by inclusive
41 language of principals and teachers and everybody in levels
42 of authority that the discrimination against LGBTI people
43 is not acceptable in this school, in this health service,
44 you know, in this workplace, everywhere.
45
46 And it's the vigilance of calling it out as
47 bystanders. You know, "That's so gay" in the classroom,

1 every teacher needs to call that out and understand that
2 statistically there will be an LGBTI person in that class,
3 whether they've come out or not.
4
5 Look, I remember talking to an aged care provider who
6 said, "We don't have any LGBTI people in here." I said,
7 "How many residents do you have?" He said, "Over 100." I
8 said, "You do, you have about 10 at a minimum, go find
9 them." How do you do that? Provide safe places, they'll
10 eventually come out, but you can't expect them to, you have
11 to just assume that they're there. That's so important for
12 schools.
13
14 When we do intake, data intake at a school, if you're
15 a school counsellor and you say to a young person, "Do you
16 have a boyfriend or a girlfriend?", and you just ask
17 everybody. The young boy, "Oh, I don't have a boyfriend",
18 he might come back two sessions later and goes, "Actually I
19 am attracted to boys." But until you get over the stigma
20 of asking the question in the data collection, everywhere
21 we do.
22
23 I mean, I can remember when people used to say, on
24 data forms you can't ask someone if they're an Aboriginal
25 or Torres Strait Islander, you know. There isn't a form
26 now I fill in that I'm not asked, am I Aboriginal or Torres
27 Strait Islander. And why don't we ask about somebody's
28 sexuality and gender identity and intersex variation? You
29 know, our community, we're probably not gonna choose to
30 answer it if we don't feel safe, but the fact that the
31 question is there reduces the stigma. So, it's the
32 systematic things this we put into schools.
33
34 Schools are, you know, there's so many supportive
35 stories of schools that are working with kids that are
36 transitioning. You know, it's not the teachers that have
37 the issues around kids transitioning in schools - it's just
38 not. They are constantly ringing up the Safe Schools team.
39 As late as last night I was given a briefing by the Safe
40 Schools team: their training sessions are packed out. It's
41 not that the teachers don't wanna come, because they know -
42 teachers in the frontline know this is critical for young
43 people. It's really just the parents and board members of
44 the school that need to get on board and see that, you
45 know, this saves lives; we're not mucking around here, this
46 is sheep stations, this is real, and it's so important that
47 we change the systems, and that we give people identity and

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

1 Q. You have been since 1993?
2 A. M'hmm.
3
4 Q. You're currently a general practitioner at Northside
5 Clinic?
6 A. Yes, I am.
7
8 Q. I'll ask you some more questions specifically about
9 Northside in a moment. But you helped to establish that
10 clinic in 2009?
11 A. Yes.
12
13 Q. You are also an Honorary Associate Professor at the
14 University of Melbourne, where you teach and conduct
15 research?
16 A. Yes.
17
18 Q. You are also the Co-Chair of the Victorian Government
19 Health and Human Services LGBTI Working Group?
20 A. M'mm.
21
22 Q. And a member of the Victorian Government LGBTI
23 Taskforce?
24 A. Yes. So, just to sort of explain my identities, as
25 they're multiple. I'll be speaking from various
26 perspectives both as a GP seeing a lot of LGBTI clients; as
27 a researcher, I've done a lot of research in this area, and
28 as someone who contributes to policy development in the
29 state.
30
31 Q. Thank you. I said I'd come back to ask you about
32 Northside Clinic, can I do that now?
33 A. Yep.
34
35 Q. You describe it in your statement as an independent
36 and private general practice in Fitzroy North. Can you
37 just explain a bit more about it in a general way?
38 A. So it's a private general practice, we have a number
39 of GPs and nurses and also allied health providers, so we
40 serve the local community as a general practice does, but
41 we also have a special focus on LGBT clients, not
42 specifically intersex clients, and sexual health and HIV
43 medicine. So, probably approximately half of our clients
44 will be LGBTI, and the other half local community.
45
46 Q. And of the half that you've said are from the LGBTI
47 community, most of those patients are adults?

1 A. Yes, although increasingly we have young trans and
2 gender diverse patients under 18 as well.
3
4 Q. Just in your role as a general practitioner, you see
5 private practice patients and in relation to both physical
6 and mental health issues?
7 A. Yeah, of course.
8
9 Q. How does the clinic cater for the mental health needs
10 of the patients you see?
11 A. Particularly for the LGBT patients there is a lot of
12 mental health that is brought to us as part of their
13 consultation. So, we discuss counselling and whether that
14 might be required, we discuss medication, but by and large
15 we do a lot of support and guidance around how to navigate
16 the system, but also how to navigate family, how to
17 navigate society around their LGBTI identities. So, I
18 think as GPs we provide a lot of support: many of our
19 clients don't progress to counselling, that just remains as
20 part of the GP-patient relationship, and then some
21 obviously would need more specialised care.
22
23 Q. Can you then just talk about the specialised care
24 that's available through Northside?
25 A. So, yeah, we've appointed several clinical
26 psychologists, counsellors and family therapists to be part
27 of our team. We've specifically identified those people
28 who we trust and know to be LGBTI inclusive: some are
29 members of the LGBT community and some are not, but through
30 word-of-mouth and through personal knowledge, we've asked
31 them to be part of the team because we trust them and we
32 hope that our patients trust them as well.
33
34 Q. There is one clinical psychologist that specialises in
35 care for trans and gender diverse clients?
36 A. Yes.
37
38 Q. In terms of the clients who are using the mental
39 health services available through Northside, they access a
40 mental health care plan?
41 A. M'hmm.
42
43 Q. And that provides them generally with 10 sessions?
44 A. Yeah, that's right.
45
46 Q. Can you just explain what sometimes happens at
47 Northside to manage the needs of those clients beyond those

1 10 sessions?
2 A. Well, that's very common, so a lot of the LGBT
3 patients that we refer for mental health support - and this
4 might be to our own counsellors or external counsellors -
5 they'll use their 10 sessions within the first three months
6 of the year and then have another nine months to go without
7 Medicare rebated psychology services. So, we tend to
8 manage them either through coming back regularly to the GP
9 or referral back to their own counsellor, but with an
10 arrangement that might be a reduced rate from the
11 counsellor.
12
13 One major issue, that there's very few, if any, bulk
14 billing counsellors and psychologists who are in the system
15 who also understand and are good at LGBT care, so it's a
16 huge financial burden for those patients to then undertake
17 further counselling without the Medicare rebate.
18
19 Q. And so, this arrangement that you've described is the
20 individual choice of a practitioner to choose to reduce the
21 rate that they receive?
22 A. Yes. Most of our counsellors would do that, many of
23 the counsellors I refer to outside of the clinic will also
24 do that, have a reduced rate on a case-by-case basis
25 depending on the patient's needs and economic
26 circumstances.
27
28 But it's a major level of stress for those patients
29 because, you know, I often see them after they've had their
30 10th session, they feel at a loss, they don't know whether
31 to continue to access that service, they can't really
32 afford to do that, so we end up having the sort of burden
33 of care back into the primary care system.
34
35 Q. I've asked you about, or you've described the mental
36 health services available through Northside Clinic.
37 Northside is also co-located with the Mind Equality Centre?
38 A. M'hmm.
39
40 Q. Can you briefly describe what that is, we'll hear
41 evidence about that later but just briefly?
42 A. Yes, I'm very pleased that Mind is presenting, I think
43 it's a wonderful model. Mind approached us, we had a space
44 to rent and they approached us when they were considering
45 setting up their LGBTI Equality Centre, this was about
46 three years ago. They had identified the need to serve
47 this community in a more professional and detailed way in a

1 specific clinic. We thought that was a very good
2 association that we could develop and it has been the case.
3
4 They've set up next to us in rooms that they rent from
5 us. It's quite an independent relationship, but we do
6 refer patients actively to them and vice versa to us, so
7 it's been a very good arrangement. Being next door, it
8 means we can go and talk to each other about clients, we
9 can have discussions on the phone because we know each
10 other really well, and I think our patients appreciate that
11 too.
12
13 Q. Can I move on to ask you about the groups within the
14 LGBTIQ+ community that are most likely to access services
15 and why that is?
16 A. I know that Ro presented issues around barriers to
17 services, and I totally support her words there, but I have
18 noticed in my practice and also through my research that
19 there's a high level of access to mental health services
20 amongst this community.
21
22 What we don't really know is whether that level of
23 access is commensurate to need, and I suspect that the need
24 is even higher than the access.
25
26 So, what I've seen in my research is that a large
27 number of people are accessing mental health services, and
28 I would include general practice, primary care, mental
29 health nursing, counselling support and the hospital
30 inpatient services in that category.
31
32 It's over-represented amongst certain subgroups of
33 LGBTI people, particularly trans and gender diverse people
34 are accessing the mental health services at a high rate,
35 and also some subgroups, particularly bisexual and
36 pansexual people, and this is what we've seen in the
37 research around the need, there's much higher levels of
38 need amongst the transgender diverse, pansexual, queer and
39 bisexual groups.
40
41 Also, clearly amongst other groups, but perhaps they
42 don't access services as readily, such as refugees, asylum
43 seekers, people with disability and so on.
44
45 Q. One of the matters you note in your statement is that
46 there's more likely to be access by urban dwellers as
47 compared with people living in rural communities.

1 A. This is a point of great concern amongst those of us
2 doing this work. I mean, my clinic is based in an inner
3 urban setting, so is the other equivalent clinic in the
4 south; we don't have clinics like ours in the outer urban
5 area or rural areas, and this means that there's less
6 knowledge and understanding of who to refer to in the
7 mental health system.
8
9 We also don't have readily identifiable LGBTI expert
10 counsellors in rural and outer urban settings, so I think
11 this is a major limitation, and I see this in my client
12 group: a lot of patients come to our clinic from rural or
13 outer urban areas of Melbourne and Victoria. My first
14 point is, "Why do you come here when you live
15 100 kilometres away?" And they say, "I just don't know who
16 to go to in my local area", or "I have tried a local
17 counsellor or local GP and found that they, firstly, have
18 no understanding of my specific issues; secondly, they felt
19 they were homophobic or transphobic; thirdly, they didn't
20 know who to refer me to", so the default was to come to our
21 clinic which, you know, I hope that in a decade, two
22 decades, our clinic doesn't need to exist, and we shouldn't
23 need to exist: this should be the case for any person going
24 to any general practice or community health service in
25 Victoria, that they can access care that is knowledgeable
26 and understands the system well enough to refer them to a
27 locally inclusive provider.
28
29 So, at this point we exist to serve that need, but
30 hopefully we won't need to in the future.
31
32 Q. I might ask you about that more a bit later. Can I
33 ask you now about particular groups though that you might
34 not have much knowledge about, and lack of access by those
35 particular groups.
36 A. In research and also in the community discussions
37 we've been having - firstly I'll focus on asylum seekers
38 and refugees. This would be one of the most disadvantaged
39 groups of LGBTI people in Victoria. They live in Victoria,
40 they often don't have access to Medicare. They also don't
41 have access to the LGBTI community, and this is often
42 related to their fear of being outed in their community or
43 their family discovering that they're LGBT back home.
44
45 They feel very concerned about discussing LGBT issues
46 when an interpreter is present, because the interpreter is
47 naturally from their own community, so there's a lot of

1 fear around discrimination within the community and I think
2 this creates a huge lack of access to appropriate services
3 and care.
4
5 So, I understand for many asylum seekers I've talked
6 to, and this is through my work on the Pride Foundation
7 Australia, that they don't feel services understand their
8 specific needs around their LGBT status. For many of them,
9 they've come to Australia as a refugee because they're LGB
10 or T and their own country of origin criminalises their
11 activities. So, it's very difficult for them to prove that
12 they're LGBT, which is one of the requirements to attain
13 refugee status, so this is an extremely difficult position
14 to be in.
15
16 They also have often very major trauma histories
17 through their refugee experience. So, I fear that most of
18 those people are not accessing the mental health system as
19 they could and should be doing.
20
21 Another major subgroup are people with disabilities:
22 Ro mentioned them in her evidence. We know that people
23 with a disability who are also LGBT often have difficulty
24 understanding their sexuality or gender identity in
25 relation to LGBT community. So, they don't feel like they
26 can access community very easily. They don't feel they can
27 discuss their LGBT status openly with a health provider for
28 similar reasons that a family can be very involved in a
29 caring capacity for people with disability, are often in
30 the room or closely connected with the health provider, so
31 issues of confidentiality are very difficult to maintain.
32
33 A person can feel that they can't expose or disclose
34 their sexuality or gender identity to a health provider
35 because of fears that their family will discriminate
36 against them, or worse, reject them.
37
38 Q. You say in your statement that further research is
39 required with respect to how these groups access mental
40 health services?
41 A. Definitely. They're quite underserved, both in the
42 health system and in research.
43
44 Q. Can I ask you now about the most common barriers to
45 accessing mental health services, and in particular for you
46 to please address the internal barriers and the external
47 barriers: just starting with the internal barriers and what

1 that includes?
2 A. Just to put this into context, I did a piece of
3 research for Beyond Blue about four years ago: they asked
4 me to look at lesbian/bi women and I extended that to queer
5 women and transgender diverse people and their mental
6 health and access to the mental health system. So, we did
7 this by doing an online survey, that was responded to by
8 about 1,600 people in Australia, and then did some key
9 informant interviews with health providers and services as
10 well.
11
12 The issue there, we obviously did a lit review and
13 tried to understand what were some of the key barriers that
14 were uncovered in the literature as well as my
15 understanding from the clinical practice. So, we made a
16 division between internal and external barriers to access,
17 because they're important.
18
19 So, firstly, internal barriers: I mean, these are some
20 things that might arise because of homophobia, internalised
21 homophobia, biphobia or transphobia, and just to define
22 that: that would be, let's say you've grown up in a family
23 that often vilifies gay or lesbian people. There might be
24 commentary around media engagement with that group, so the
25 child is learning and listening to this discussion and can
26 take on those values for themselves. But as it emerges in
27 their own mind that they're lesbian, gay or bi or trans,
28 they've already learned these negative stereotypes, so it
29 becomes internally focused and they say, well, that means I
30 must be wrong, evil, inadequate in some way.
31
32 So, if one has this feeling of internalised
33 homophobia, biphobia or transphobia, it can mean that you
34 don't feel worthy of accessing support, that this is not a
35 legitimate issue, and so, that can be one of the major
36 barriers to seeking support. So, one might describe, for
37 example, I've got a young bisexual person in my practice at
38 the moment, she's about ██, she describes very clearly this
39 idea that she's had throughout her life that being bisexual
40 or lesbian is just completely wrong. She's from a
41 faith-based family.
42
43 And so, she's grappling with this constantly at the
44 moment, you know, is it right or wrong? You know, which is
45 my moral compass? How do I determine that when my family
46 are so clearly on that side of the equation? And, I'm the
47 first person that she's discussed her bisexuality with.

1 She feels that this is immoral for her to feel like this,
2 and so, I'm trying to work with her on how to reframe her
3 moral system, which is a huge thing to do for anyone, in a
4 situation where her most close support comes still from her
5 family.
6
7 So, I think for this young woman: she's ██, she's been
8 grappling with this for years, has only just come to a GP
9 to talk about the issues. There's no way she will access a
10 mental health provider at the moment because she feels that
11 she would just have to reveal this immorality to someone
12 else, so it will require several months or years of
13 discussion before she can access. So, from her
14 perspective, that is a very major internal barrier, this
15 sort of moral compass.
16
17 Q. One of the things you mention in your statement about
18 one way to overcome that internal barrier, in a system
19 sense, is to enhance mental health literacy?
20 A. Yes. I mean, I'll come to that a bit later perhaps,
21 but the idea that - I mean, this woman isn't attached to
22 the LGBT community at all, so I think this would be a very
23 difficult thing to do, to draw on community assumptions or
24 advice - she's not connected yet, perhaps she will be in
25 the future.
26
27 But that's one idea more broadly, is to look at how we
28 can communicate this to the LGBTI communities, to say, you
29 are allowed to access mental health services; in fact it's
30 a good idea; in fact it's better than that, it's an
31 excellent idea and there are great people out there who can
32 help you. So, this is something that's emerging in our
33 communities as an important message for health promotion,
34 not just for mental illness, but for this young woman that
35 wouldn't work.
36
37 Another of the internal barriers is an idea of needing
38 to be self-sufficient. I think we've seen this, if we look
39 at the gendered or binary gender of the mental health
40 system access, we know that women are much more likely to
41 access counselling than men, for example. It's a similar
42 issue around men in our society needing to feel
43 self-sufficient, sufficiently regard themselves as the sole
44 person who is guiding their own life, and so, to let that
45 guard down and say, no, I do need a bit of help here, it's
46 okay to get some help, I think that's also a problem for
47 some LGBTI people. They just feel that this should be part

1 of what they do anyway in their life.
2
3 Turning to external barriers: I think Ro's really
4 touched on this largely, but it's partly about knowing who
5 to see who will be LGBTI inclusive; that can be really
6 difficult to understand. Perceived discrimination Ro's
7 talked about as well.
8
9 I wanted to touch on an issue of continuity of care
10 because I think this is another major external barrier.
11 So, if a person has attempted to access - whether it be a
12 primary care provider or a mental health provider - and
13 found that person to be lacking in their LGBTI
14 inclusiveness or knowledge, then they might doctor-shop:
15 they might work through the system to find other people and
16 in the end might have seen six, eight, 10 different people.
17 I've got many patients in this category who have seen many,
18 many counsellors but only for very brief periods of time.
19
20 So, first they lose the motivation to see more
21 counsellors because they don't feel they've had an adequate
22 level of support or benefit, so they've lost trust in the
23 system, and so, we've lost that opportunity up to a
24 point to encourage them to see someone on a regular basis.
25
26 So part of what I'm doing with patients in that group
27 is re-engaging them with the system, saying there are
28 supportive, inclusive counsellors out there, I know them,
29 I've worked with them, I've had good feedback from other
30 people in your position, and trying to re-engage and
31 encourage continuity, so a relationship that's long enough
32 to develop a deeper understanding of the person and
33 therefore reach a deeper level in counselling.
34
35 Q. Can I ask you about poverty and financial inequity
36 being another major barrier to accessing mental health
37 services.
38 A. So, I know the Commission has received a lot of advice
39 already about financial inequity: that's not new to you at
40 all. But for this group, we know that poverty is one of
41 the underlying issues that create health inequalities for
42 LGBT people.
43
44 I'll just give you an example: this is a woman I
45 interviewed for one of my research projects a few years
46 ago. She was ██ at the time, lesbian, had had a lot of
47 family violence as a young person and had left home early

1 as part of my homelessness research. So, she had left home
2 at about the age of 15 because she felt that her home
3 environment was not supportive: more than that, was
4 violent.
5
6 She'd been homeless for many years, at least a decade
7 of her life, from about 15-25, and as a result of that had
8 had no access to education or training. And at about 25
9 managed to exit the homelessness system, find accommodation
10 and start training.
11
12 So, at the age of 29 she was looking at her peers and
13 saying, they've all achieved their degrees, they've
14 achieved status in their various occupations, they've got
15 into a committed relationship, they're starting to think
16 about buying a house, and she was reflecting on her life:
17 she was still training, she wasn't in a committed
18 relationship, she still had unstable housing, and she was
19 extremely poor.
20
21 So, you know, she was an example of what happens
22 frequently in this community, with repeated or confounding
23 factors that affect mental health and the ability to
24 progress in life: it's a repeated story equally for people
25 who are transgender diverse, for gay men. This is a huge
26 issue around accessing education and training, and
27 therefore accessing a good workplace and secure employment
28 and income.
29
30 So, with that as a background, many, many LGBT people
31 don't have enough money to finance through the private
32 mental health system and have to rely on the public mental
33 health system, which is difficult to say the least.
34
35 Q. Are there barriers greater for certain groups, and if
36 you could address what you describe as marginal and
37 emerging identities as a starting point?
38 A. So, you'll be very aware that this community is
39 diversifying rapidly. We have a hugely diverse group of
40 young people, and people of any age actually, who are
41 understanding their gender in a diverse way now, with many,
42 many different terms that are out there, increasing all the
43 time which I find difficult in training, because I'll give
44 people a set of terms and then in a few months the terms
45 have changed and they come back to me and say, "You didn't
46 tell me that term", and I say "I've only just learned it
47 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.

1 I wanted to mention another group which is around
2 people with trauma histories. So, again, if we're looking
3 at perhaps underlying reasons for the high, the very high
4 mental health inequalities in this group: one of the
5 underlying issues seems to be trauma, and not just one
6 episode of trauma but repeated re-traumatisation for
7 people. This might be a trajectory from family violence or
8 family rejection, through to rejection or trauma within the
9 education system, in workplaces and within society
10 generally.
11
12 So, these people, again, have even higher difficulty
13 finding appropriate services: you know, services that both
14 understand their trauma history as well as understand their
15 LGBT status and other disadvantage. So, it's a concern
16 that the most vulnerable members of this population can't
17 access appropriate care.
18
19 Q. Can I ask you now about what the enablers are for
20 people accessing mental health services? So, what makes a
21 good service?
22 A. We tried to look at this from a research point of view
23 in the Rainbow Women's Society I talked about before that
24 was funded by Beyond Blue, in some work I've done with
25 alcohol and accessing alcohol services for lesbian and bi
26 women. The enablers seem repeatedly to be the same. So,
27 first, accessing a GP that is supportive: that seems to
28 have a high level of agreement in the surveys, and I
29 understand this to be about, if one has a supportive GP and
30 can come out to that GP as LGBT, then this can enable
31 uncovering of other related issues.
32
33 And so, one's mental health that might have been quite
34 suppressed in the conversation, you know, a person would
35 often come to a GP first for their physical health issue,
36 the mental health's in the background, they're testing the
37 system; is it going to be supportive? Okay, yes, then I'll
38 disclose that part of me as well.
39
40 So I think having a GP where there's some continuity
41 of care, there's a relationship developing, there's a level
42 of trust, the more difficult issues are raised over time,
43 and then this same GP can refer out to the appropriate
44 services. So, that's one enabler that's incredibly
45 important.
46
47 Another is community support. So, I've mentioned this

1 already, but if there is a supportive peer group who is
2 like-minded and has collated information about what's out
3 there in terms of support, and shared that knowledge in the
4 group, and indeed encouraged people to access supportive
5 care, then that will be an enabler for mental health
6 support and care
7
8 As I said, I think people who have found such a group
9 have a much better chance of recovery because they can find
10 the right people to go to and be encouraged to maintain
11 that relationship.
12
13 Q. What about having reliable information about what
14 services are available?
15 A. Yeah, I mean reliable in terms of word-of-mouth: I
16 think at times people have different experiences in health
17 services, and this can be very difficult when I'm training
18 service providers. You know, we can't be all things to all
19 people, and I know that at our clinic we've received
20 criticism because we've not dealt well with a bisexual
21 person, we've not understood a trans or gender diverse
22 person very well. I mean, there's a high bar that we've
23 set and we need to be criticised to be sure that we're
24 maintaining a good standard.
25
26 Having said that, some people will have a uniquely bad
27 experience based on a difficult receptionist, or it was a
28 bad day for the clinician: that's not an excuse, but that
29 person has had a bad experience, so unfortunately that can
30 filter through peer support groups and that clinician or
31 service is no longer acceptable in the group. So, I think
32 up to a point that can be a very difficult situation,
33 because in fact that group or service might be entirely
34 appropriate.
35
36 So I think - we'll come to peer support in more detail
37 but I think that's one of the very difficult things for a
38 peer support organisation to do, is to navigate how these
39 services appear to individuals, yet how they might be
40 supportive to the whole community.
41
42 Q. You also mention in your statement access to
43 counselling services online can be particularly important
44 for young people.
45 A. Yep.
46
47 Q. And so, can you just tell the Commissioners about

1 that?
2 A. I've talked with Headspace quite a bit about their
3 services, because clearly there's an online Headspace, and
4 they've set that up deliberately for both rural and remote
5 young people, but also young people who just can't
6 physically attend a service. They have found that to be
7 very effective.
8
9 Recently in the last two or three years Headspace have
10 started collecting data on sexual orientation and gender
11 identity of the people who access their online service, and
12 it looks like in most areas it's between 20 and 25 per cent
13 of the young people accessing the online Headspace service.
14
15 This is much higher than you would expect from
16 population data, so I think this supports the theory that
17 we've been developing for quite a while that a number of
18 LGBT people would put their toe in the water in an online
19 service: let's test the system, let's see if I'm going to
20 get some support that's affirming of my sexual orientation,
21 gender identity, and having had that affirming care in an
22 online service, they will then be more likely hopefully to
23 access face-to-face services.
24
25 So, that's certainly the case at Headspace, and I can
26 see there's a few emerging online services that are
27 specifically designed for LGBT people with mental health
28 issues. Out and Online is one example. ReachOut is doing
29 some work in that area. Beyond Blue are looking at some
30 online support as well they've specifically targeted at
31 LGBT people. I think that's an incredibly valuable
32 addition to the mental health service.
33
34 It doesn't replace face-to-face services in any way,
35 but I think it enables access for people who are rural or
36 remote, and hopefully enables the building of trust in the
37 system.
38
39 Q. Can I take you back to Northside Clinic and ask you
40 some questions about the inclusive care that's provided
41 there.
42 A. We pride ourselves in being a high quality general
43 practitioner which is accredited and so on, but we also
44 have additional processes that we have developed over
45 the years, and mostly through word-of-mouth and feedback
46 and internal discussion on how to be more inclusive for
47 LGBT clients. I'm deliberately not discussing people with

1 intersex variation because we haven't yet enabled those
2 systems in our practice and we need to.
3
4 So, for LGBT clients, we start with, what's the face
5 of our clinic to the community? So we do advertise our
6 service actively in the LGBT community. We attend
7 midsummer carnival, we have a stall, we run blood pressure
8 checks and things, but it's really just to help people know
9 who we are and meet us.
10
11 You know, we have the rainbow flag at the front.
12 Having said that, that's not the only thing. If you just
13 had a rainbow flag and nothing else, that's actually a
14 really poor approach, because people can let their guard
15 down a little. As Ro said, she feels more comfortable when
16 she sees the rainbow flag, but if nothing happens after
17 that, you've let your guard down and you've been
18 disappointed - that's no good.
19
20 So, you know, that imagery on the front of the clinic
21 around saying that we're LGBT inclusive, having imagery
22 that's appropriate, is the first step. Then training the
23 receptionists to be appropriate, to use appropriate
24 language. I mean, these are very simple steps, it doesn't
25 cost money, it's just a process. To understand that we
26 don't have to use titles, we don't have to use Mr, Mrs, Ms,
27 Dr, this is not relevant to one's health care in any way
28 and it removes a significant barrier for some people.
29
30 An example is we used to send - we still do - send
31 letters out to our patients reminding them they need their
32 cervical screening. The letter used to say "Dear Ms X";
33 well, we have a number of trans men who need cervical
34 screening as well. If that letter says, "Dear Ms X", they
35 will be horrified, it would be completely inappropriate,
36 and it would probably mean they wouldn't come in for their
37 cervical screening let alone anything else. So, there's no
38 need to have a title in letters on their medical file so
39 we've removed that altogether.
40
41 Likewise when we call names in the waiting room, we
42 try to ensure we're calling the appropriate name, not the
43 so-called debt name or their birth name, that's
44 particularly important for gender diverse and trans
45 clients.
46
47 But also some LGB clients change their name, and this

1 is related to difficulties in family circumstances, so we
2 need to be sure that we're using the name they select
3 rather than their Medicare name. So, we've trained
4 receptionists to be appropriate around not using titles,
5 using appropriate gender, using appropriate names, and also
6 being very careful around confidentiality.
7
8 Our clinic is a melting pot and a meeting point, so
9 people often see each other in the waiting room, that's not
10 always a good thing. The receptionists sort of look out
11 for that and can help negotiate what's happening in the
12 waiting room.
13
14 And then, attempting to improve the way we offer
15 services within the consulting room, and that's around
16 again confidentiality, training ourselves in the LGBT
17 community issues that are most important, and the top of
18 the list is mental health and suicide prevention,
19 understanding drug and alcohol issues that are specific to
20 subgroups in the community, engaging with appropriate
21 counselling staff and so on.
22
23 I think another big part of it is developing our
24 referral networks, which we do gradually over time, based
25 again on feedback and meeting different providers, so
26 understanding who is supportive of this community, and not
27 just supportive, but affirming of LGBT status.
28
29 So, these are all things that are fairly easy to
30 institute in a clinic such as ours or any other general
31 practice.
32
33 Q. Commissioner Allen mentioned this morning the Rainbow
34 Tick: is that something that Northside Clinic has or wants?
35 A. M'mm. We have looked into doing Rainbow Tick
36 actually, just to say we've got it. I think we have pretty
37 much done all of the things that would be required in the
38 Rainbow Tick, and we haven't got Rainbow Tick at the
39 moment.
40
41 I feel that Rainbow Tick is one end of the spectrum of
42 inclusive practice. It's most helpful for large
43 organisations that have an infrastructure that can
44 introduce all of the system change that's required by the
45 Rainbow Tick accreditation. For smaller practices such as
46 ours and health services, we don't have the infrastructure
47 to create that enormous amount of change, but we do have a

1 set of very clear directives that we've provided for our
2 staff.
3
4 Q. You mentioned the role of peer support workers briefly
5 earlier. Can you just address that topic now and
6 particularly with regard to your academic work on the
7 subject?
8 A. So, I think if there's one system reform that you
9 could focus on most for our group, it is supporting the
10 peer support work that's happening in our community. This
11 is partly because, as Ro was saying, it's about resilience
12 building, but mostly because a lot of the LGBT patients I
13 see in my clinic rely almost entirely on peer support as
14 their mental health support.
15
16 So, as we've said, there are a lot of barriers to
17 accessing the mental health system. For those particularly
18 marginalised groups, the only level of support they get is
19 through a peer support group, and this is not ideal, but
20 it's the reality at the moment.
21
22 So I think what we're needing to do is integrate the
23 peer support system into the mental health system in a much
24 more effective way: to have methods of cross-referral so
25 that practitioners know these peer support groups exist and
26 can refer to them, but also to have methods for the peer
27 support workers to refer into the mental health system, and
28 at this point that's not happening effectively.
29
30 One of the key points is that, if peer support workers
31 are looking after a group of LGBT people with significant
32 mental health concerns, generally speaking they have not
33 had adequate training to do that, and they know that
34 themselves, they're crying out for some training and
35 support, because this is a complex group of people, often
36 with complex trauma histories. Within one group setting,
37 particularly when there's - well either online or
38 face-to-face - networking in the group, there can be quite
39 a lot of lateral violence in the group. Difficulties with
40 policing identities or with understanding who is in a
41 relationship with who.
42
43 So peer support workers need a great deal of training
44 to understand how to deal with those issues, how to address
45 lateral violence, for example, in a safe way so that the
46 group is sustaining and not re-traumatising. So, I think
47 that's a huge issue that can be addressed within the

1 Victorian health system.
2
3 Q. And so, in addition to that change, there are other
4 systematic changes that you perceive as desirable. Can you
5 please address - and you've already touched on this - but
6 the idea of mental health practitioners receiving adequate
7 training in relation to LGBTI inclusivity, and so, you said
8 that needs to be more broadly applied?
9 A. Yes. We have a problem with LGBT inclusion in
10 curriculum at all levels at the moment. It's very
11 piecemeal, it's not embedded in curriculum in most training
12 organisations. It happens, if there's an individual
13 champion, and sometimes that appears for a few years and
14 then disappears again if that champion has left the
15 organisation, and this would be whether it be at university
16 level, at a training organisation or at a continuing
17 professional development level. So, I think there's a
18 major issue at the moment in understanding how are we going
19 to address more systematic training within the sector.
20
21 There's certainly individual work happening. I've
22 been working with Queer MD which is a group of LGBT medical
23 students at Melbourne Uni and they've got colleagues both
24 at Monash and Deakin. They are raising issues of needing
25 to have LGBT inclusion in the curriculum, and have been for
26 a number of years. It's still regarded as quite a marginal
27 issue in the curriculum and really only appears in the
28 student conference that is student led and delivered. So,
29 you know, that's at this stage falling on deaf ears by and
30 large.
31
32 And this is partly because there's a huge competition
33 for curriculum and do we have - where do we sit in the
34 hierarchy of need. But I think we can make the case, and
35 we have made the case already, that there's a huge need in
36 this community that can be addressed through curriculum
37 change.
38
39 Okay, that's a systematic approach to understanding
40 that LGBT needs to be embedded, just as Aboriginal and
41 Torres Strait Islander health has been embedded in the
42 curriculum over the last 20 years. Easily done, I hope,
43 over time.
44
45 As Ro said, I think a lot of LGBT people resent having
46 to train their health provider in their own specific
47 identity, and this is a conundrum that I have in training

1 health providers, because on the one hand I'm saying to
2 people, please listen to your patient, listen to your
3 client, try to understand their perspective, their
4 individual identity, how does that play out in their life?
5 But that can easily become a little mini training exercise
6 from the patient to the clinician. And, as Ro said, that
7 was a very difficult thing that they identified and
8 understood in their own life.
9
10 If people had done that two or three times, they start
11 to resent it so much that they maybe decide not to come out
12 to a new provider, it just becomes too difficult, and their
13 own issues are lost in that. So, we need to avoid that.
14
15 Q. I'll just ask you briefly about some other systematic
16 changes and then move on to what you ultimately would
17 recommend. You say that there needs to be greater work
18 done on mental health promotion.
19 A. M'hmm.
20
21 Q. There are good examples of that with the National
22 LGBTI Health Alliance and what's been produced there. In
23 addition to that, further research into LGBTI mental health
24 and health care needs to occur, and further data collection
25 by mainstream services.
26 A. Look, just focusing on mental health promotion for a
27 moment, we're starting to build a literature around
28 resilience. So, it's been difficult because until quite
29 recently we've had to focus in on the negative statistics
30 to raise the awareness and to make the case for curriculum
31 inclusion in training and to make the case for inclusive
32 practice.
33
34 The argument has been, well, there's a much higher
35 need, there's a much higher burden of mental illness in
36 this LGBT community, so we need more focus and more
37 attention. That can be quite pathologising for the
38 community; it is very pathologising. A lot of community
39 members, whether they've experienced personal mental health
40 problems or not, worry about the fact that they'll be
41 assumed to have a mental health illness because they're
42 LGBT.
43
44 So I think, to try and avoid or reverse that approach,
45 I think we need to be looking at resilience building as a
46 really important strategy, and also how we're already
47 enabling resilience in the community, it comes back a

1 little bit to the idea of internal barriers to seeking
2 help.
3
4 So, if we've come from a point of saying, we have
5 internalised homophobia for example, how do we overcome
6 that, and it's partly about systematic change clearly, but
7 partly about, let's build our own LGBT community support
8 and resilience, let's celebrate ourselves, let's understand
9 what we're good at: we're very good at peer support, we're
10 very good at connection, we're very good at reaching out
11 for those marginalised groups. We're better than many
12 other communities at doing that, let's celebrate that and
13 support it.
14
15 So, I think we can make a greater effort to do that.
16 I mean, the Victorian State Government have done some
17 amazing work recently in leadership training for young
18 LGBTI people, and those new emerging leaders are starting
19 to look at this idea of resilience and positive support,
20 supporting our positive mental health, so that's a huge new
21 wave I think that we can look forward to over the next
22 few years.
23
24 The mental health promotion: there's a little bit
25 happening, for example there was a document produced about
26 mental health first aid, specifically for LGBTIQ
27 communities. It's a nice brief, four, five-paged document.
28 A bit of guidance for whether it be peer support groups, or
29 parents or schools, any level of community, to say how can
30 we pick up early signs, early intervention, and prevent
31 longer term problems.
32
33 Another lovely piece of work that is about to start is
34 primary prevention for families around trans and gender
35 diversity. So, building an education piece for families,
36 and this is particularly looking at multi-cultural
37 families: you know, how do we support the family to
38 understand what is trans and gender diverse, that it's a
39 nominal variation of gender identity, and that we can
40 helpfully help them to understand this before they present
41 negative attitudes to their children. So, I think that's
42 going to be a really lovely piece of work to focus in on in
43 the next few years.
44
45 Q. Can I ask you then, just finally, in relation to the
46 key changes?
47 A. So, there's been work done on this over the last

1 10 years or so. The key piece that I'll refer you to is: A
2 Closer Look At Private Lives. So, this Private Lives 2 was
3 a big LGBT health survey that was done in 2010. Beyond
4 Blue sponsored some additional analyses of that survey to
5 look at mental health, and out of that analysis, plus the
6 work that we were doing on the LGBTI ministerial advisory
7 group at the time, we developed a policy and program
8 framework for mental health support.
9
10 And really, it looked at a three-level system or
11 three-tiered system of support in the mental health system.
12 So, we felt that the majority of LGBTI people needing
13 mental health support should be able to access that through
14 the mainstream system, but that all areas of the mainstream
15 system needed to be LGBTI inclusive. So, that would
16 involve, as we've discussed, training, accreditation,
17 whole-of-system change. Whether that be Rainbow Tick or
18 not is a question to be discussed.
19
20 Then the second tier were mainstream services that had
21 an embedded LGBTI stream. So, an example of that is the
22 Mind Equality Centre, for example, or perhaps more recently
23 the community health system in Victoria. There's a new
24 LGBTI inclusive practice toolkit that's going to be
25 released in a couple of months that is encouraging a sort
26 of embedded LGBT stream within community health. So it
27 might be identified practitioners who are LGBTI champions
28 who would preferentially see those clients.
29
30 Then the third tier would be for that minority of the
31 most vulnerable of LGBTI patients who for many reasons
32 don't feel comfortable to access mainstream mental health
33 services and who need peer-led, LGBT-led system. So, that
34 might be people who go to Thorne Harbour Health, work
35 through Switchboard, go to Drummond Street services.
36
37 Again, at the moment all of these LGBTI-specific
38 services are based in urban areas: there's very few, if
39 any, that will be in the rural sector. So, if we had a
40 concerted effort to develop a three-tiered system like
41 this, we would need to address specialist services in rural
42 areas as a key point, and/or more online and
43 teleconferencing accessibility.
44
45 Q. Can I just pick up on, just finally, one question you
46 raise, the point about Rainbow Tick or not. Could you just
47 very briefly address that?

1 A. I think we've learned some lessons from the family
2 violence sector in the last couple of years. So, there was
3 a recommendation from the Family Violence Royal Commission
4 that all family violence services in Victoria should
5 receive the Rainbow Tick accreditation, and that was an
6 astounding recommendation, it was fantastic actually to
7 acknowledge the need for that training.
8
9 But it created problems on the ground, because many
10 family violence services are tiny, they have a very small
11 staff group, a large volunteer group as well, and it
12 emerged that, for those smaller organisations, it was very
13 difficult to obtain a Rainbow Tick: it's an expensive
14 process, it takes a lot of time. I think VincentCare, it
15 took them a couple of years. They employed a worker two
16 days a week for that two-year period to enable Rainbow
17 Tick, so that's not possible for small organisations.
18
19 I think a recommendation that's broader that's around
20 LGBTI inclusive training and system change would be
21 appropriate, because then that can cover off small
22 organisations, it can cover off organisations that are
23 already doing the work, such as Northside; it doesn't have
24 to be Rainbow Tick, there can be a number of levels before
25 that.
26
27 So, I think Family Violence in the end have come down
28 to an idea that, in one region there's a Rainbow Tick
29 accredited service, all the other smaller services do some
30 training in the area, and then can work with that Rainbow
31 Tick accredited service as the local peak, if you like.
32 That seems to be a better way to navigate that approach to
33 the system, and this would certainly apply for the mental
34 health system where there are many small services that are
35 operating that probably can't access Rainbow Tick but could
36 do some work in upskilling.
37
38 MS COGHLAN: Thank you, doctor. Chair, do the
39 Commissioners have any questions?
40
41 CHAIR: Professor Fels.
42
43 COMMISSIONER FELS: Q. Thank you for your evidence, I
44 have two questions. One, is there data about the economic
45 status of LGBT people?
46 A. Yeah, there is. So, the HILDA survey, which is a
47 national household survey, is starting to indicate that

1 some groups of LGB - and we don't have trans or gender
2 identity in that survey - but the LGB community have a
3 lower economic status than equivalent heterosexual.
4
5 There's also some data that will be coming out from
6 the Victorian population health survey. We hope that
7 report will be out in a couple of months. I'm not at
8 liberty to give you that information at the moment because
9 it hasn't gone to the Minister, but I have seen the data
10 and it confirms significant areas of economic disadvantage
11 for LGBTI community in Victoria.
12
13 Q. Thank you. My second question is something that's
14 been raised by GPs before, and I'm talking about the GP,
15 not the psychology bit, that the MBS fee schedule, how do
16 you view it with your interest in LGBT, it tends not to -
17 to the extent you're driven at all by economic incentives,
18 it doesn't encourage lengthy consultation and so on.
19 A. Quite.
20
21 Q. Can you comment on your perspective on that?
22 A. Yes, that's totally correct. So, example: if I see a
23 person in 15 minutes, which will be a standard general
24 practice consultation time, that's a level B consultation,
25 so that's remunerated at a certain rate. If I see them in
26 30 minutes, which is more likely for some of the complex
27 issues that I have to deal with for LGBT community, I'm
28 remunerated at a level C, which is about a third again on
29 top of the level B rate. So, it's not double. So, the
30 more level Cs or longer consultations I do, the less money
31 I get per day, and that's economically a problem. I'm
32 trying to run a practice.
33
34 I mean, we've talked with Mind Equality recently about
35 the fact that they're bulk billing most of the providers
36 that got to that - sorry, the patients that go to that
37 service and that's not sustainable in the long term.
38 Equally for our clinic it's not sustainable to bulk bill,
39 we have to add an additional charge for two-thirds of our
40 patients.
41
42 So, when we're talking about complex mental health
43 care, and particularly in a scenario where a patient cannot
44 or does not want to go to a mental health provider, the
45 burden of care rests on the GP. We have extended 30 or 45
46 minute consultations with patients on a regular basis with
47 minimal remuneration, all bulk billed, so this doesn't

1 work.
2
3 CHAIR: Q. Thank you very much. I'd like to ask just
4 one other question which goes to that issue of the burden
5 of care. I was mindful throughout your evidence of talking
6 about the fact that many of the people you see are
7 reluctant to go and seek access to specialist mental health
8 services, and I noted you said also for those who are
9 accessing peer support, many times people are overwhelmed
10 by the complexity of the mental health issues they're
11 presented with.
12
13 What role do you think there is for secondary
14 consultation? If people don't want to access the
15 specialist mental health services, how can you bring
16 sometimes that greater expertise you might need in the
17 management to reduce that burden of care, I guess, or share
18 the burden of care?
19 A. I think that has a huge role to play. An example is,
20 the Monash Gender Clinic is now offering secondary
21 consultation for GPs. So, Jaco Erasmus is the Head of the
22 Monash Gender Service and is also a psychiatrist, sees a
23 lot of gender diverse and trans patients in his private
24 practice as well. So, he started offering a secondary
25 consultation service in the last couple of years,
26 particularly for rural and remote GPs, but also anyone in
27 the urban sector.
28
29 It means that a GP can see a patient who's trans or
30 gender diverse, talk about their complex needs, talk to
31 Jaco and get some discussion about how to deal with
32 whatever it is, and it might mean that they don't have to
33 see Jaco at all. So, I think that would be fantastic if we
34 can have a service that is extended beyond transgender
35 diverse to all the LGBTI communities.
36
37 Just to touch on intersex for a moment: most GPs that
38 I know, and I'm certainly in that group, don't have
39 expertise in seeing people with intersex variations. The
40 literature is still really poor on what are the mental
41 health concerns for people with intersex variations. We've
42 touched on it a little bit in Ro and my evidence, so that
43 needs more research. But, you know, to have secondary
44 consultation based on - and whether it be children or
45 adults, who have intersex variations, if we could talk to a
46 psychiatrist or endocrinologist about these issues, we may
47 be able to retain that patient in our system rather than


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1 refer them out for specialist care, which I think is a
2 principle that works for the health system generally, of
3 course.
4
5 CHAIR: Thank you.
6
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.
11
12 <**THE WITNESS WITHDREW**
13
14 MS NICHOLS: The next witness is Associate Professor
15 Michelle Telfer. I call her to give evidence now.
16
17 <**MICHELLE TELFER, affirmed and examined: [12.29pm]**
18
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
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.
2
3 Q. Can you tell us, in short, what is meant by the term
4 "transgender" so we can be clear about that?
5 A. Transgender?
6
7 Q. Yes.
8 A. So, transgender is an umbrella term that covers a
9 number of different trans identities, and a young person is
10 trans when they're sex assigned at birth, which is
11 determined by their physical anatomy, does not match with
12 their gender identity. Their gender identity being the
13 deep inner sense of whether someone is male, female or
14 somewhere in between.
15
16 Q. And, what about "gender diverse"?
17 A. Gender diverse is similarly used in this context as an
18 umbrella term. As Commissioner Allen and also Dr McNair
19 had described, there are lots of different terms that cover
20 this population. Trans and gender diverse were used as the
21 overall term that pretty much encompasses everyone, and
22 certainly for the purposes of today I'll use trans and
23 gender diverse to encompass everyone.
24
25 Q. Thank you. I want to ask you about how the mental
26 health outcomes of trans and gender diverse young people
27 compared with those in the general population. We've heard
28 a little bit about that already today. Can I just ask you,
29 from your perspective on the basis of the experience you've
30 had, do trans and gender diverse young people experience
31 higher levels of discrimination, stigma and bullying?
32 A. They do. The best evidence we have in Australia comes
33 from a study that was nationwide, online study, conducted
34 in 2016 and published in 2017. It's known as the Trans
35 Pathways Study and that looked at 859 young people between
36 the ages of 14 and 25.
37
38 This particular population of trans and gender diverse
39 young people were nationwide not particularly well
40 supported in terms of their physical and mental health.
41 The outcomes are frightening for us who work in this field,
42 where 75 per cent had been diagnosed with depression;
43 72 per cent with anxiety; 80 per cent had tried to
44 self-harm at some stage, and 48 per cent had attempted
45 suicide.
46
47 We know from our own anecdotal experience with the

1 gender service that, with excellent family support and
2 medical services, including specialist services, that these
3 rates are somewhat lower, and certainly what we see is, a
4 large number of young people who come in having experienced
5 self-harm and suicide attempts who improve with regards to
6 their mental health once they receive that support.
7
8 Q. The study you just mentioned, that's an Australian
9 study?
10 A. That's right, was conducted across Australia.
11
12 Q. Is there international data to indicate that there's a
13 demonstrated risk of increased homicide when openly
14 identifying as being trans or gender diverse?
15 A. That's correct. That data comes from the USA. We
16 don't have comparable data here, but the data in the US
17 certainly suggests that being trans and gender diverse, and
18 expressing that gender diversity is a major risk for
19 homicide.
20
21 Q. What are the sources of stigma that trans and gender
22 diverse young people experience?
23 A. I often go back to a common definition of stigma,
24 because I think it's helpful to think about it in this way,
25 in that, stigma is a mark of disgrace that really isolates
26 a person from others or separates a person from others. We
27 know that having depression or anxiety, having self-harm or
28 attempting suicide, causes stigma.
29
30 But what we know from trans and gender diverse young
31 people, is that, they experience stigma just for being
32 themselves. So, being transgender alone is enough to have
33 a mark of disgrace. And, with that stigma comes obviously
34 the discrimination, the social exclusion, the family
35 rejection and so forth, and that leads to the mental health
36 problems that we've discussed.
37
38 So, there's almost like an exponential rise in stigma
39 because you're stigmatised for who you are, and then
40 stigmatised for the negative consequences of that original
41 stigma.
42
43 I think, in my view, that's the reason why the mental
44 health outcomes are so poor in this group, and are so
45 difficult to change, because the stigma is experienced not
46 only in wider society, but the young people experience
47 stigma from their parents, from their siblings, from their

1 peers at school, from their teachers, in all sorts of
2 aspects of their lives.
3
4 And I've witnessed myself in my clinic, only just in
5 the last few weeks, having a parent tell their child, their
6 very intelligent, empathetic, very generous child, that
7 they are a disgrace on the family, and that sort of thing
8 really affects us as clinicians, and I couldn't imagine
9 what that must have felt like for that young person.
10
11 So, we see it firsthand as well as hear about it from
12 the young people as an experience of their daily lives.
13
14 Q. Have you had experience of transgender and gender
15 diverse young people failing to complete school despite
16 having high academic ability?
17 A. Absolutely. Trans and gender diverse young people,
18 when they're at school, experience a high degree of
19 bullying and hostility and sometimes even physical assaults
20 at school, and often can't persist with their schooling
21 because of that hostile environment. A lot of these young
22 people are very high achieving, very intelligent, have
23 great academic potential.
24
25 Many go into distance education and try and complete
26 their schooling that way, but that creates a whole other
27 level of social isolation and it can be really difficult
28 coming from a place of being isolated to really reach that
29 potential and get through to where they should be, which is
30 being at university and achieving high results.
31
32 Q. Is there a longitudinal cohort study which is being
33 carried out by the Royal Children's Hospital Foundation,
34 and partly funded by the Victorian Government, looking at
35 outcomes for trans and gender diverse young people over a
36 period of 20 years?
37 A. Yes, that's correct. So, there's very little
38 longitudinal data looking at long-term outcomes for
39 children and adolescents: partly because the specialist
40 care that we provide really has only been in existence
41 internationally over the last 20 years.
42
43 So, when the State Government gave us the funding to
44 commence a specialised gender service we felt it was
45 necessary to evaluate our outcomes. We started to measure
46 with everyone who came into the service, their physical
47 health, their mental health, their family function, their

1 level of bullying and other measures really to look at
2 where they're at at the beginning.
3
4 We then follow these young people with surveys as they
5 go through the clinical service, and we're currently funded
6 for four years, but I ambitiously called it Trans 20,
7 hoping that we would be able to keep it going for 20 years,
8 because I think that's where its value lies in looking at
9 that long-term data and actually using that data to improve
10 outcomes into the future.
11
12 Q. Do preliminary results as at about now show a link
13 between experiences of bullying and mental health issues,
14 with 17 per cent of trans and gender diverse young people
15 who are experiencing bullying showing a high risk of
16 suicide, compared with 8 per cent for those who didn't
17 experience bullying?
18 A. That's correct. So, there was a high rate of bullying
19 itself compared to the general population, and those that
20 were bullied were significantly worse off in terms of
21 suicidality.
22
23 Q. Could I ask you about the mental health outcomes of
24 trans and gender diverse young people compared with the
25 broader LGBTQI community?
26 A. Yes. So, when we look at the suicide or attempted
27 suicide rates in the trans and gender diverse community,
28 they are higher than any other group that I'm aware of. I
29 think that, in terms of social acceptance of trans
30 identities, we're still quite a long way behind the
31 acceptance of the lesbian, gay and bisexual communities.
32
33 We saw from the marriage equality debate leading up to
34 the postal survey that this was certainly evident, with the
35 "no" campaign actually using transgender children as a
36 source of fear for those who might be thinking of voting
37 for marriage equality.
38
39 They produced this campaign through the television and
40 through social media which really did demonise trans
41 children in the sense that what they said is, with this
42 slippery slope argument, that if we have marriage equality
43 there will be more transgender children. And, not only did
44 they suggest that this is possible - because it's not,
45 no-one can create someone's gender identity - but not only
46 did they suggest it was possible, but they suggested that
47 that was something to fear and something parents would or

1 should be concerned and worried about.
2
3 Q. What do you say about the notion that children don't
4 absorb the nuances of adult debate about social policy?
5 A. Yes, well, I think as we've heard from Commissioner
6 Allen, children are very perceptive with regards to what's
7 going on in the world around them; and, not only that,
8 they're very IT savvy and able to navigate the internet and
9 social media really well. But even really young children
10 pick up on what's being said, whether that's in the home,
11 at family events or at school.
12
13 It's just like, I suppose, being in a room where you
14 hear your name mentioned, you sort of turn around to see
15 what's being said, and for children and young people who
16 are needing to be vigilant about their environment and
17 knowing when it's safe to express how they feel or not,
18 they are vigilant, hypervigilant, when it comes to
19 information that's out in the media and the noise that's
20 being created with this.
21
22 I think, when social commentators talk about
23 transgender children and demonise or vilify them, they're
24 really projecting that view to the adult audience and to
25 try and create fear within that adult audience, but the
26 people that get hurt the most are the trans children who
27 are experiencing it in that very personal way and who are
28 taking it all in.
29
30 We know they're taking it in because parents tell us
31 how their mental health is affected at these times where
32 there is a lot of noise in the media. But also, at the
33 Children's Hospital where we're known as a very
34 gender-affirming safe space to be, they'll come in and tell
35 us about how it's really upsetting them, and they look to
36 us for reassurance, that they're okay, that they're
37 worthwhile and that they deserve to be loved by their
38 family and taken care of by their doctors.
39
40 Q. Can I ask you now about that service. The service is
41 now an internationally leading statewide specialist
42 service. Can I take you back to 2015 when it was created.
43 What were the circumstances that led to the investment of
44 money that made that service possible?
45 A. If you don't mind me going back even further?
46
47 Q. Absolutely.

1 A. That would be probably helpful in setting the scene
2 for it. The Royal Children's Hospital had its first
3 transgender patient present for care in 2003, the second
4 patient presented in 2005, and the third in 2007, so it's
5 fairly recent in terms of medical care for the Children's
6 Hospital.
7
8 I joined the service in 2012, and that year we had 18
9 referrals, so still a very low number. What was happening
10 at that time was that there were a number of individual
11 clinicians who were seeing patients within their overall
12 practice, fitting them into their clinics and providing the
13 care that was required, and that was fine when the numbers
14 were low and it was fairly easy to manage.
15
16 Between 2012 and 2014 there was an exponential rise in
17 referrals, and in 2014 we had 104 new patients, which
18 obviously overloaded these clinicians, and it wasn't
19 possible to see them all in a timely manner. Actually,
20 what happened in a short period of time is that the waiting
21 list blew out to 14 months.
22
23 And we know that the time on the waiting list is a
24 dangerous time, because in terms of risk of suicide the
25 highest time of risk is the time between coming out, as
26 Commissioner Allen was saying, but also the time which is
27 kind of related to that, is when a person decides that they
28 want to seek care and actually time that they can access
29 care. So, having a long waiting list is literally a killer
30 and it's also one of those entities which you can't define
31 because you don't know the people that are on that waiting
32 list.
33
34 So, for me, being responsible for the adolescent
35 medicine team, and we held the responsibility for what was
36 the gender service as such, was that, I felt that the risk
37 was too great and the responsibility I wasn't comfortable
38 with in certainly going about things the same way.
39
40 Q. Do you mean, the risk of suicide amongst young people
41 who were waiting to get in?
42 A. On the waiting list, that's right. Because we hadn't
43 met these young people before, we didn't know who they
44 were, what their level of risk was, but we knew it was
45 going to be high.
46
47 So, with the support of the Executive of the Royal

1 Children's Hospital, we approached the government at the
2 time to ask for some help to make sure that these young
3 people were looked after and were safe. And at this stage
4 it was 2014 and there was a state election that year, and
5 so, we met with the government of the time and we also met
6 with the opposition.
7
8 And what has been really interesting for me was that,
9 about two weeks before the election Four Corners did a
10 story called, Being Me, and Being Me featured two highly
11 intelligent articulate young trans girls, Georgie Stone and
12 Isabelle Langley, and they talked about their stories and
13 their families and they also talked about how the Royal
14 Children's Hospital had helped them and how they were doing
15 well because of the support that they'd received.
16
17 And, as I think you've probably seen with this Royal
18 Commission, it's the personal stories that make the
19 difference, that make things make sense. And, following
20 the election, we had the Labor Government come into power
21 and we worked closely with them to then get a funded
22 service up and running. And, from the beginning, I have to
23 say, they have been extraordinarily supportive. I mean, it
24 helps having a Minister for Equality and a Minister for
25 Mental Health who has come in being very well informed on
26 the issues at hand.
27
28 There was an announcement that the gender service
29 would receive $6 million over four years to establish
30 itself as a service. And, with that money, because we had
31 no structure in place, it was a really good opportunity to
32 actually put together an efficient evidence-based service
33 right from the start.
34
35 So what I did was, I hired 12 part-time staff: so we
36 had paediatricians, psychologists, child and adolescent
37 psychiatrists, and some gynaecological support and also
38 included in that team was a clinical nurse consultant and
39 others, and we've been able to produce outcomes over the
40 four years which has, as you mentioned, led to
41 international acclaim and, if I may indulge myself, we have
42 been written up in The Lancet as a world-leading service
43 for children and adolescents who identify as trans and
44 gender diverse.
45
46 Q. Can I ask you about the multidisciplinary and
47 integrated nature of your service: how that works and why

1 it's important that it has those two features?
2 A. Yes. So, multidisciplinary integrated care really is
3 a system of care that brings together disciplines across
4 medical mental health and allied health specialities. And,
5 when you bring together that expertise in a co-located
6 environment, you can create a team that is there to
7 primarily support that young person at the centre, their
8 family and their extended support networks.
9
10 So, how that might work in a practical context with
11 the Royal Children's Hospital is, if I use the example of a
12 10-year-old who comes to see us. We run an initial triage
13 assessment. Once we receive the referral, that's done by a
14 clinical nurse consultant or a junior doctor, and that's
15 really to assess the level of risk, as well as to provide
16 support and education to that young person and their
17 family, and we also link them into community-based support
18 so that we know that, whilst they're waiting for further
19 care they can access what they need in the community: sort
20 of primary care and across community-based mental health
21 services.
22
23 We also then allocate them a paediatrician and a
24 mental health clinician. So, that mental health clinician
25 may be a child and adolescent psychiatrist or it may be a
26 psychologist, and the paediatrician and the mental health
27 clinician form the base of that multidisciplinary team and
28 they make decisions together along with that child and the
29 family.
30
31 And why this works, is that - and I should add, sorry,
32 that although we have the core paediatrician and mental
33 health clinician as the base of that team, we also have
34 subspecialty expertise with gynaecology, with speech
35 pathology, with others that we can bring in as required
36 over the life course of that person's care at the
37 Children's.
38
39 And why I think it works, why it's been acclaimed as a
40 way that we've been able to achieve good outcomes, is
41 because the co-location and the multidisciplinary nature
42 allows really efficient and effective communication; it
43 provides a safe place for families to ask questions and to
44 make plans with us collaboratively.
45
46 It also, I guess, in terms of that emotional safety,
47 they have a home, they know where to come if they have any

1 problems and they know how we can be contacted as things
2 arise and we can be flexible within that team.
3
4 Q. Is there a misconception in some parts that the role
5 of the mental health clinician is to diagnose gender
6 dysphoria?
7 A. Yeah, it's really interesting when we think about
8 mental health clinicians within the context of trans and
9 gender diverse children, because you don't really need
10 someone to diagnose a person with gender dysphoria, because
11 a trans identity is something that's so innately personal
12 that really only that young person or adult, depending on
13 what time of their life they're coming in, only they know
14 how they feel about their gender and whether that's a
15 problem or not for them.
16
17 The mental health clinicians really have a role in
18 managing the consequences of that person's experiences when
19 they're living as a trans person, or trying to help them
20 understand some of the feelings that they may have and
21 their fears and anxieties, as well as the - obviously, we
22 manage risk and so forth.
23
24 But I think what's really important to note as well,
25 is that, it's not just the mental health clinicians within
26 our team that are there to support mental health, because
27 for trans and gender diverse children it's actually the
28 medical interventions as well as some surgical
29 interventions that help their mental health.
30
31 So, for young people they often say, "I don't need to
32 talk about this any more, I just actually need to
33 transition", or for someone who might be 12 or 13, "My
34 emerging puberty is causing me so much distress", that the
35 only way to manage that distress and the consequences that
36 come from that distress is actually to have the physical
37 interventions from the paediatricians with puberty
38 blockers.
39
40 So, as a team, it's not just the mental health
41 clinicians that are responsible and are effective in
42 improving someone's mental health, but it actually takes
43 all of us. So, from the paediatricians, our clinical nurse
44 consultant, our speech pathologist, everybody has the
45 primary goal of working to help that young person be who
46 they are and, in that way, improving and maximising their
47 mental health.

1
2 Q. What are the trends in the demands for the service at
3 the Royal Children's Hospital?
4 A. Yeah, so if we go back then to 2014, it has continued
5 to increase exponentially, and that's not just because of
6 who we are and that we've got a service that's accessible,
7 but it's a phenomena that is consistent across western
8 societies. As trans people have become more visible, and
9 as expressing one's trans identity has become more socially
10 acceptable, what we've seen are large numbers of people
11 coming forward.
12
13 So, the graph which is included in my submission shows
14 this rapid rise. Last year we had 269 new referrals, and
15 we've just done the figures for 2019 for the first
16 six months of the year, and that's 20 per cent above
17 last year's number, so it's likely that we'll be receiving
18 over 300 new referrals this year.
19
20 And when you think that we're a statewide service,
21 we're the only specialist service for trans and gender
22 diverse children and adolescents in Victoria, we don't
23 treat these young people for a short time, we keep them and
24 look after them and care for them usually until they finish
25 Year 12 when they can be transitioned into adult care, so
26 our numbers increase accumulatively as the years pass.
27
28 Q. And the costs of providing that kind of care are high,
29 aren't they?
30 A. They are high, and if you think back to that number of
31 new referrals, 104 in 2014 when we were negotiating with
32 government about funding for the gender service: we've now
33 had a 300 per cent increase based on the figures for
34 this year, a 250 per cent increase if you look at the
35 numbers from 2018, so we're trying to do the same care with
36 three times the number of young people, and it's actually
37 more than that because of the accumulation of patients over
38 time.
39
40 Q. And the same funding?
41 A. Yes, the same funding. So, our four years of funding
42 actually ran out two and a half weeks ago on 30 June, and
43 we're currently working with the Department of Health and
44 Human Services on how it's going to be funded from here.
45
46 I'm confident that the Victorian Government have a
47 really good understanding of what the needs of this

1 population are, and I know that they're very keen to
2 continue to see good outcomes and that they know the
3 pressures that we're under at the Royal Children's Hospital
4 in terms of numbers.
5
6 They're also aware that what we've seen is that we've
7 continued to do the triaging assessment not long after
8 young people are referred, so we're seeing them quite
9 quickly, but what's happening now is that the time between
10 that point and seeing the paediatricians and the
11 psychiatrists and so forth is stretching further and
12 further apart.
13
14 So, whilst we're doing our best to stay on top of it,
15 it's a constant challenge and we haven't seen any increase
16 in funding and I'm hoping that that will come.
17
18 I think, with a service like this, where you have a
19 uniquely vulnerable population, there's always going to be
20 a need to look at care in a complex way and to do what you
21 can to get good outcomes, and essentially save lives.
22
23 From a department perspective or what have you, I
24 think there's always going to be a risk that they will want
25 to fit you into existing funding mechanisms, and this is
26 something that - a risk that we carry and an anxiety that
27 we carry because of the politicisation of trans health and
28 trans children in particular, that with changes in
29 government we might end up having to really struggle to
30 find that funding.
31
32 What's really clear to us is that activity-based
33 funding, or the current systems that are often used to
34 allocate funding, really don't cover the cost of providing
35 good care for this vulnerable group. And it's because
36 activity-based funding is really based on the face-to-face
37 interactions at the hospital with the young person and the
38 clinicians, but we do more than that when we are providing
39 great care, because the problem itself is not actually the
40 child in front of us; the problem is their environment that
41 they're often living in.
42
43 So, we don't just focus on the child, we are focusing
44 on the child, their parents, which may be mum and dad, it
45 might be a stepmum, a step-dad, the siblings, the
46 grandparents, schools. We also have to work with other
47 care providers such as foster carers, carers in residential

1 units or elsewhere to make sure that we're providing
2 comprehensive and holistic care, and none of that is
3 covered in activity-based funding. The calculations that
4 we've done at the Children's suggests that only a third of
5 our costs would be covered, and obviously our waiting lists
6 would blow out if our staffing was reduced by that much.
7
8 Q. How do young people without supportive families get
9 access to a service like yours?
10 A. Yeah, well, we see - that's a good point, because we
11 only see young people that have at least one parent who's
12 supportive, because to come to a specialist service you
13 need to get a referral from a GP, and then come in to the
14 Royal Children's Hospital. So, most kids need a parent to
15 assist them with that.
16
17 I have to say, we have had a couple of young people
18 who are highly resilient, very resourceful who have managed
19 to do it on their own, but it's pretty rare. So, there is
20 a whole population, I suspect, of young people who aren't
21 able to access our service because they don't have that
22 family support, and I think that's where the school system
23 is really important in looking after these children and
24 adolescents, but we don't know who they are and we can't
25 measure them, so it's very much an unknown.
26
27 Q. We've asked you some questions about what changes
28 you'd like to see systematically to the mental health
29 system to better address the mental health needs of trans
30 gendered young people. You've already mentioned secure
31 long-term funding for specialist multidisciplinary
32 integrated gender services, and we've probably covered that
33 one.
34 A. I did.
35
36 Q. And you've emphasised secure and long-term.
37 A. Yes, thank you.
38
39 Q. Are there other aspects of systematic reform that you
40 would like to emphasise?
41 A. Yeah. I think, when we're talking about the most
42 vulnerable, they're the ones without the family support,
43 without the parents that can bring them in, and we've seen
44 great success with Safe Schools and also with the Doctors
45 in Secondary School Program, which my team has been
46 involved in, in terms of providing secondary advice and
47 education.

1
2 I feel that, if we could extend and build on the
3 success of Safe Schools and the Doctors in Secondary
4 Schools Programs and put mental health clinicians within
5 schools, then that would provide a great resource for young
6 people who don't feel supported at home.
7
8 There has been some of this work starting with some
9 psychologists in schools actually being recently
10 implemented by government, but I really think that it would
11 be worthwhile to extend it out.
12
13 And existing services that are community-based tend
14 not to be connected to the other services. So, for
15 example, if we take community-based psychologists and so
16 forth, when you're a statewide service and you're dealing
17 with psychologists across the state, trying to communicate
18 patient information and treatment plans and so forth with
19 lots of different people can be really inefficient.
20
21 But because we're dealing with the schools often
22 anyway, and supporting that young person in schools, if we
23 had the mental health support in the school as well, it
24 would just provide, I think, a better more well-rounded
25 level of support for each of these young people.
26
27 So there's the school level, there's the primary
28 health care level, which I think Dr McNair has described
29 very well, and then there's the next level which is the
30 specialist services, which I won't go into because we have,
31 as you've explained.
32
33 But we need to have the support at all of those levels
34 and, taking it a step further, I think integrating with the
35 adult gender services as well and ensuring that transition
36 is happening so that people aren't falling through the
37 cracks.
38
39 Q. Just on that point: is transitioning occurring well or
40 at all between the child and adolescent and the adult
41 services for trans and gender diverse people receiving your
42 kind of care?
43 A. Yeah, we're very lucky in Victoria because we've got
44 fantastic specialist GP practices like Northside Clinic and
45 Equinox, and Prahran Market Clinic as well. Because most
46 of our young people have gone through a multidisciplinary
47 assessment and care, by the time we transition them into

1 adult services, usually after they've finished VCE or once
2 they turn 18, around that time, they often don't need
3 specialist care through the Monash Gender Clinic, they just
4 need good general practitioners who can continue on with
5 that level of support and hormone prescribing.
6
7 We do have some young people that have severe mental
8 health impairment who do need specialist mental health
9 psychiatrists to be involved, but they're usually the
10 minority actually. And, we've developed really strong
11 relationships with both the Monash Gender Clinic and the
12 specialist GP practices, and we develop relationships with
13 young people's GPs, their family doctors that they've been
14 with for a long time, over the time period that we've
15 looked after them. I'm often very pleasantly surprised
16 with how many GPs wish to take on the care and have learnt
17 through the communication with us what to do and feel
18 confident to carry on with that care.
19
20 Q. Thank you. Dr Telfer, is there anything that I've
21 missed out that you really wanted to say?
22 A. I guess, just as a final comment, I do understand that
23 this is a very supportive environment here today: I think
24 trans children are often demonised and vilified in the
25 media, and we all have probably seen how brutal that can be
26 for them.
27
28 But I just want to say that, there is absolutely
29 nothing to fear from supporting trans children. Trans
30 children don't come with a political agenda, they just are
31 being themselves, and I think what is ultimately what these
32 children and adolescents want is what all children and
33 adolescents want, which is to feel love unconditionally by
34 their families, to go to school and do well and have
35 friends, to go to TAFE or university and get a job and have
36 relationships and have their own family. Often that really
37 basic message around, just want to have a safe, normal,
38 happy life, is lost with all the noise that's often
39 generated more widely.
40
41 MS NICHOLS: Thank you very much. Chair, are there any
42 questions for Professor Telfer?
43
44 CHAIR: Yes, Professor McSherry.
45
46 COMMISSIONER McSHERRY: Q. Thank you very much,
47 Associate Professor. Just one question from me. You've

1 mentioned in your statement a bit about the tyranny of
2 distance, those living in rural and regional areas. But
3 you've mentioned shared care: could you perhaps tell us a
4 little bit more about that, how that would work for people
5 living in rural or regional areas?
6 A. Yeah. So, about six years ago there was a nurse
7 consultant up in Wodonga who approached us from a service
8 called Gateway Health. And Wodonga had a number of trans
9 and gender diverse young people who were seeking primary
10 care there, and she said that she'd identified some
11 specialists who were interested in becoming involved with
12 their care.
13
14 What we managed to do is to provide some education and
15 training to two paediatricians and a child and adolescent
16 psychiatrist who are based in Wodonga. We developed a
17 shared care model which initially we required - to provide
18 quite a lot of support for these specialists in helping
19 them manage patients, but actually six years on they're
20 doing it on their own, they're highly capable, and these
21 young people from Wodonga, whilst we're aware and sometimes
22 intervene with their care in terms of providing that highly
23 specialised interventions such as fertility preservation
24 procedures, et cetera, they really don't need to come to
25 Melbourne any more and they're receiving their care in
26 Wodonga.
27
28 I was only there a couple of weekends ago and seeing
29 some of the young people who I looked after as young
30 children who are now doing really well as older
31 adolescents, and they've been able to set up a wonderful
32 service.
33
34 So, I think, if we could do the same in other areas of
35 regional and rural Victoria, we could access these
36 vulnerable children and provide much better care for them.
37
38 COMMISSIONER McSHERRY: Thank you.
39
40 CHAIR: Q. There's just one other point I'd like to
41 raise, Associate Professor. In the material you gave us
42 and in the attachments it did show the data about the high
43 prevalence of mental health distress and risk. As a result
44 of the interventions through your clinic, have you been
45 able to measure improvements in mental health and wellbeing
46 and reduced risk of harm and suicidality, for example?
47 A. Yeah. So, Trans 20, which is the longitudinal cohort

1 study, has generated some preliminary data that we haven't
2 yet published, we're in the process of trying to publish
3 that. But what we've seen in the first year of engagement
4 with the service is that levels of depression and anxiety
5 have decreased significantly, and we've seen improvements
6 in quality of life.
7
8 We've also done some qualitative work around their
9 experiences of accessing the service, and that's been
10 really positive, with the families and the young people
11 themselves expressing an increased sense of agency over
12 their own health, their own identity and their own ability
13 to navigate society and their life in general, with
14 improved levels of confidence, as well as engagement and
15 also their sense of self, which has been very much improved
16 by having the Children's Hospital being involved in their
17 care.
18
19 Q. Thank you very much.
20 A. In terms of suicidality, it's probably too early to
21 look at the actual numbers, but I have to say, in the
22 16 years that the gender service has been in operation,
23 we've seen lots of young people presenting with a history
24 of attempted suicide, but once they're actually in the
25 service and getting the support, it's quite - well, it's
26 very uncommon.
27
28 I was thinking this morning actually how many young
29 people I'm aware of who have needed to be admitted to an
30 acute mental health facility because of a suicide attempt,
31 and from those who are engaged in our service, I could
32 think of four; which, compared to the Trans Pathways data,
33 where one in two were attempting suicide, it just goes to
34 show how a bit of support can turn people's lives around.
35
36 THE CHAIR: Thank you very much.
37
38 MS NICHOLS: May Dr Telfer be excused please?
39
40 CHAIR: Yes, thank you very much for your evidence today
41 and your statement.
42
43 <**THE WITNESS WITHDREW**
44
45 MS NICHOLS: That concludes the evidence until after
46 lunch.
47

1 **LUNCHEON ADJOURNMENT**
2
3 **UPON RESUMING AFTER LUNCH**
4
5 MS COGHLAN: The next witness to be called is Katie
6 Larsen. I call her now.
7
8 <**KATIE LARSEN, affirmed and examined:** [2.04pm]
9
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
14 Q. I tender that statement. [WIT.0001.0035.0001] You are
15 the General Manager, Diversity, Inclusion and Participation
16 at Mind Australia Limited?
17 A. That's correct.
18
19 Q. In that role, you oversee Mind's organisational
20 diversity and inclusion, and inclusion strategy, as well as
21 its participation and engagement strategies?
22 A. That's correct, yes.
23
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 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
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.
2
3 Q. Then, what about the Mind Equality Centre?
4 A. Yes, the Mind Equality Centre is a LGBTIQ+ specialist
5 service. It was developed in 2017 after members of our
6 senior executive group identified that there was both
7 disproportionately high rates of mental illness and mental
8 ill-health amongst LGBTIQ+ people in our communities, and
9 also that there was a lack of specialist services to meet
10 the needs of those communities.
11
12 Q. One of the things you say in your statement is that
13 the Mind Equality Centre provides a range of targeted
14 allied health supports.
15 A. Yep.
16
17 Q. Can you just explain that a bit further, please?
18 A. Yeah, so essentially we have LGBTIQ+ specialist staff
19 and they provide a range of services, allied health
20 services, through things like individual and family and
21 relationship counselling, suicide prevention and a range of
22 other counselling supports.
23
24 Q. What about the staff who are employed there?
25 A. So, the staff that are employed there are LGBTIQ+
26 specialist staff: so what that means is that they have
27 practised expertise in working with and meeting the needs
28 of LGBTIQ+ people in communities. They may be LGBTQI
29 identified themselves or they would be very strong allies
30 of the community.
31
32 Q. In your statement you say that:
33
34 "The Equality Centre meets the needs of
35 some of the most vulnerable members of the
36 LGBTIQ+ communities."
37
38 Can you just expand on that, particularly in relation
39 to the way in which the Mind Equality Centre provides
40 services?
41 A. Yeah. So, as has been discussed this morning through
42 the other testimonies, there's a range of factors that
43 contribute to the vulnerabilities that LGBTIQ+ people and
44 communities may experience.
45
46 So, we respond to those in terms of how we deliver the
47 practice that we provide, but in addition to that we also -

1 what we're seeing is a real vulnerability in terms of the
2 people who are seeking that access of a LGBTIQ+ specialist
3 service. So, about 95 per cent of the people that access
4 the Equality Centre do so through the Medicare Benefits
5 Schedule or the MBS, and of that 95 per cent, about
6 85 per cent are unable to meet the gap payment through
7 various reasons relating to their vulnerability.
8
9 So, that makes it quite challenging for us as a
10 service to be sustainable and to continue, because running
11 a service - and the Equality Centre is funded almost
12 entirely by Mind itself, the larger organisation - is
13 really challenging when not receiving those kinds of gap
14 payments, so there's a real issue of sustainability for us.
15
16 Q. So what happens in practice?
17 A. In practice, we cover the gap payment for the most
18 part, yes.
19
20 Q. Can I just ask you this: how does the Mind Equality
21 Centre address barriers to accessing mental health services
22 experienced by members of the LGBTIQ+ community, bearing in
23 mind some of the evidence that the Commissioners have
24 already heard today?
25 A. Yeah, so I just wanted to touch briefly on, I guess,
26 what we've discussed previously, so the disproportionately
27 high rates of mental ill-health and the interrelated nature
28 of those mental health rates with experiences of stigma,
29 prejudice, discrimination and marginalisation, and the
30 corresponding impact where there can be a real lack of
31 interest in engaging with mainstream health providers or in
32 accessing those services through fears of what's occurred
33 before.
34
35 So, essentially when there's been experiences of
36 discrimination or ignorance within mainstream mental health
37 services, it erodes trust in the mental health system more
38 broadly for LGBTIQ+ people.
39
40 So, what the Equality Centre seeks to do is to provide
41 a space that is culturally safe, it's welcoming, and that's
42 it's culturally safe and welcoming right through the way
43 the service operates. So, it's sort of from the moment
44 where you first have interaction with the service right
45 through your care journey with the service. So, that's
46 about having LGBTIQ+ staff who understand some of those
47 negative experiences and how they might influence someone's

1 engagement with mental health services; it's creating
2 visibly welcoming environments, which is things like
3 rainbow flags but also the publications that are visible,
4 the kinds of posters that are displayed, little messages to
5 people that this is sort of a green light of inclusion
6 space, they can feel comfortable accessing the environment;
7 forms, processes, language all those kinds of factors as
8 well.
9
10 No assumption is being made about someone's sex
11 characteristics or gender identity or sexuality and a range
12 of other factors that support that as a welcoming and safe
13 space.
14
15 Q. What's the importance of ensuring that staff are
16 experts in LGBTIQ+ practice?
17 A. Well, it means that they understand the unique needs
18 that exist for LGBTIQ+ people and communities, particularly
19 where there's increased levels of vulnerability.
20
21 What we know is that a lot of people have experiences
22 with mental health services where they may experience
23 anything from ignorance through to outright discrimination.
24 It makes it very challenging to trust a service and to
25 actually engage with why they're there, which is around
26 mental health support.
27
28 And also, it means that there can be an understanding
29 of where there might be intersections of particular aspects
30 relating to identity and also health. So, for example,
31 people who may be accessing the service that identify as
32 transgender or gender diverse and also have autism spectrum
33 disorder and understanding a little bit about what that
34 means.
35
36 So it's moving beyond sort of a broad line inclusive
37 process into something that really deeply understands the
38 diversity and the challenges and some of the complexities
39 in the LGBTIQ+ communities.
40
41 Q. You say in your statement that the Equality Centre
42 regularly engages with the LGBTIQ+ communities to ensure
43 that it understands their needs. What does that include?
44 A. It includes a whole range of things. I think we've
45 talked a lot in some of the other testimonies about
46 community, and for a service like the Equality Centre it's
47 important that we're engaged and connected with community

1 in all its forms. So, that means things like attending
2 conferences and forums and actually sharing our own
3 practice knowledge and learning from other specialist
4 providers to understand their practice experiences; sitting
5 on alliances and boards and committees; and also regularly
6 attending events: things like the midsummer carnival;
7 Pride March, those kinds of things all make a difference
8 both in terms of ensuring that the service is really
9 connected to the needs of the community and also increasing
10 visibility amongst the community that there are really safe
11 spaces that they can look to.
12
13 Q. The Commissioners have heard today about the Rainbow
14 Tick accreditation; can you just briefly describe what it
15 is, please?
16 A. Sure, so the Rainbow Tick accreditation is essentially
17 a quality framework. So, it's about assisting health
18 services to move from a place of being LGBTIQ+ friendly,
19 which is sort of that space of, we welcome everyone, we
20 respect everyone, to actually deeply understanding what it
21 is to be LGBTIQ+ inclusive, which is systematically looking
22 at how your service operates and meets the needs of the
23 community, and it's actually working proactively rather
24 than responsively: so taking accountability for a health
25 service to step right through from governance through to
26 operations a space that is LGBTIQ+ inclusive and that all
27 the systems and processes support that.
28
29 Q. And, there are six standards that need to be met or
30 built around in order to achieve the accreditation: can you
31 just very briefly identify what they are?
32 A. Yes, certainly. So, the first one is organisational
33 capability: so that's that embedding LGBTIQ+ inclusive
34 practices across systems.
35
36 Workforce development: so how staff and volunteers
37 understand their responsibilities to LGBTIQ+ consumers and
38 are trained and able it to deliver appropriate services.
39
40 Consumer participation: which is a particularly
41 important one, which is how LGBTIQ+ consumers and
42 potentially carers are consulted about and participate in
43 the planning, development, review of the service.
44
45 Welcoming an accessible organisation is the fourth
46 one, which really picks up on those kind of physical
47 environment factors as well as information structures,

1 resources and processes.
2
3 Disclosure and documentation is another key area, and
4 that's actually picking up on the particular, I suppose,
5 sensitivities or concerns of LGBTIQ+ people about how their
6 information is stored and, if they do choose to disclose,
7 around their sex, sexuality or gender identity, that they
8 can be assured that information is kept safely and there
9 are good processes in place around confidentiality.
10
11 Culturally safe and acceptable services: so, that's
12 how services identify, assess, analyse and manage risks to
13 ensure cultural safety of LGBTIQ+ consumers.
14
15 Q. The Mind Equality Centre achieved the Rainbow Tick
16 accreditation in February 2018?
17 A. Correct.
18
19 Q. In terms of the process of achieving it, how long did
20 it take?
21 A. It took about 12 months, and that was with pretty
22 intensive work around it. So, we had two primary staff
23 members guiding that process, the practice leader of the
24 Equality Centre at the time and also a quality and practice
25 advisor based at our central office.
26
27 So they attended the HOW2 program which is run by
28 Rainbow Health Victoria, formerly GLHV. So that was four
29 sessions, four workshop days but in between that a range of
30 steps undertaken to start building competency with the
31 Equality Centre and supporting elements of the
32 organisation, and there were reviews of policies,
33 procedures and systems to ensure they complied with Rainbow
34 Tick standards as well as finding where the gaps were
35 within our organisation in that process.
36
37 Being the Equality Centre, being a one service within
38 our larger organisation, that meant that the level of
39 change required at that deeper systematic level would be
40 less than a large organisation doing it for the
41 whole-of-organisation.
42
43 Q. Can I ask you about that whole-of-organisation: it is
44 the intention that Mind will seek to achieve the Rainbow
45 Tick?
46 A. Yes.
47

1 Q. Why, apart from what you've identified, why is that
2 going to be much more difficult to do?
3 A. I think it's just a more resource-intensive and
4 time-intensive process. Because, the great thing about the
5 Rainbow Tick is, it really doesn't leave any stone unturned
6 around LGBTIQ+ inclusion. So, it asks you to embed change,
7 both culturally and technically across the organisation.
8
9 So, to do that we have an organisation of over 900
10 staff operating across four states and a range of different
11 models of service that we deliver on also, each with their
12 own processes. So, while we have overarching organisation
13 processes and policies, we also have one specific to the
14 service. So, it's a process of exploring all of those
15 areas and ensuring that they comply with the Rainbow Tick
16 standards. So, it's a process whereby we have committed a
17 staff member part time to work on that over the next
18 18 months, we're aiming to have the Rainbow Tick early
19 2021, and also kind of recognising that there's a resource
20 element more broadly than that, so that particular staff
21 member as well as support from myself and other departments
22 within the organisation. Which will be probably most of
23 our central office functions, I would think, would be
24 involved in some way in supporting that process.
25
26 Q. What sort of financial investment is needed for that?
27 A. Well, a very conservative estimate, I think, is about
28 $60,000 which accounts for the staff time of the person
29 appointed to the role, some other resources from my unit
30 and from our quality and practice team, but it doesn't take
31 into account things like paid consumer and carer
32 participation, our executive time and also our
33 organisational functions time: things like IT, payroll, HR
34 and other systems that will need to support the changes.
35
36 Q. Why is it considered that the Rainbow Tick
37 accreditation is so important?
38 A. Well, aside from the reputation in the sense that it
39 offers a market to LGBTIQ+ people and communities that it's
40 a safe organisation to respond to, it's a quality
41 assurance, I think.
42
43 It's about, for many LGBTIQ+ people when they're
44 accessing mainstream mental health services, it can be a
45 matter of luck as to whether that is a positive or a
46 negative experience. That luck can be based on a whole
47 range of factors: it might be the staff members you

1 encounter; it might be your geographical location in terms
2 of understanding an awareness of LGBTIQ+ issues in that
3 area; it might be the buy-in of leadership, that this is a
4 really important function of the organisation; or any other
5 range of factors.
6
7 The Rainbow Tick sort of takes all that chance out of
8 it, I think. It works very systematically to provide
9 assurance right across the organisation and it's centred
10 around - it moves beyond goodwill and good intention into
11 really accountability around leadership: it's actually sort
12 of opening your organisation up to be reviewed and
13 considered and how well you're actually meeting all of
14 these elements which the Rainbow Tick guides on in terms of
15 a fully inclusive experience.
16
17 Q. Can I ask you about the challenges facing the mental
18 health system in being inclusive and how you would address
19 that?
20 A. Yeah. So, there's sort of four key challenges that I
21 would see in the issues that we were discussing today.
22 First is the lack of funding and prioritising of
23 population-specific mental health services for LGBTIQ+
24 communities. So, particularly for people who live outside
25 of inner city Melbourne in terms of access to something
26 that really understands the complexity of need that
27 sometimes exists.
28
29 So, that spans every aspect of the mental health
30 services, from counselling, to GPs, to bed-based services.
31 One of the things that we've discussed internally at Mind
32 is the lack of specialist services that are particularly
33 looking at bed-based environments for trans and gender
34 diverse people. So, you're looking potentially there at
35 complexity around an environment when someone is living for
36 a short period of time and there needs to be real
37 understanding of issues around sexual safety and risk
38 mitigation and trauma-informed practice which is
39 interrelated with identity. So, we have those process in
40 place, but there's another layer there to ensure that
41 people who are trans and gender diverse are able to access
42 the services and spaces in bed-based environments that
43 aligned with their gender identity and that they're able to
44 do so feeling supported, not only by staff but also by
45 other clients.
46
47 I think that's a really key aspect of this discussion,

1 and it sort of leads into my next point, is that, we have
2 environments that directly meet the mental health needs of
3 people trying to access them. So, while LGBTIQ+ specialist
4 services are absolutely crucial and Commissioner Allen
5 talked about centres of excellence earlier today, and I
6 think that's absolutely spot on in terms of what we're
7 thinking about, we also need to make sure that if people
8 are in acute or inpatient or crisis environments they have
9 access to the best mental health support for the experience
10 that they're having. So, we need to look at that within
11 specialist services and ensure that they're available as
12 long as they do not consistently get addressed in the
13 mainstream environment.
14
15 That said, I think we also need to look at the
16 mainstream mental health service environment and I think
17 there's some urgent areas that we need to address in that
18 space, again, so that people can access the mental health
19 services and environments that are most critical for the
20 care that they need.
21
22 I think, to do that, mainstream mental health services
23 really need to better appreciate and respond to the role
24 they have in providing safe and accessible services, and
25 that's across the board in the mental health system. And,
26 if we don't have that in our mainstream mental health
27 system, then I think it's also really important to
28 acknowledge that we're actually failing to meet the needs
29 of some of the most vulnerable people in our communities,
30 and that's LGBTIQ+ people as well as other people from
31 marginalised populations. If we're not meeting the needs
32 of the most vulnerable, then I don't think we're meeting
33 the needs of the communities that we're working in.
34
35 And, whether in LGBTIQ+ specific or mainstream
36 settings, we need to be able to respond to
37 intersectionality and in that I mean, that while it's
38 important that we have population specific responses around
39 LGBTIQ+ people in communities as well as other communities,
40 for example Aboriginal and Torres Strait Islander, and I
41 know CALD communities will be discussed tomorrow, we also
42 need to recognise that people don't exist in isolation in
43 one identity or another. There's a whole range of ways and
44 experiences that make us who we are, and our mental health
45 system actually needs to be able to understand that too.
46
47 I think often we have LGBTIQ+ services over here, and

1 then services for other communities over here, and what
2 happens when someone who's Aboriginal and gay wants to
3 attend to go to a service that's culturally safe? Where is
4 that service currently? That's the question I would ask.
5
6 So, one of the things we're trying, and looking at at
7 Mind, is really a broader notion of cultural safety, and in
8 doing that as well as attending to population-specific
9 responses, actually looking at broader concepts of
10 inclusion and understanding things like unconscious bias
11 and power, and privilege, and equity, and ensuring that in
12 the way that we respond to inclusion, as well as looking at
13 those unique needs of populations, we're also having a
14 broader discussion about how identity intersects with poor
15 mental health outcomes and how that's interrelated with
16 systematic discrimination and oppression, what we've talked
17 about here today.
18
19 And, if I can just make one final point on that area,
20 which is that, I think - and I think this has come through
21 this morning as well - but when we're talking about the
22 mental health service system and specific populations and
23 communities, we're not just talking about mental health
24 services. We could create the perfect mental health system
25 for LGBTIQ+ communities, which would be fantastic, but
26 unless we're also dealing with systematic issues and
27 individual issues around homophobia, biphobia, transphobia
28 and interphobia, we're still going to see the
29 disproportionate rates of mental ill-health until our
30 communities and our society more broadly is safer for
31 people who are different and sit within these communities,
32 I think we still have a long way to go and I think that the
33 mental health system has a responsibility in also attending
34 to that aspect of the work.
35
36 Q. Can I just ask you, this will pick up on some of the
37 themes that you've raised: beyond those matters that you've
38 already raised, what else can be done, and this is from a
39 systems point of view, to be more responsive, suitable and
40 inclusive of LGBTIQ+ consumers?
41 A. So, one of the things that I think is absolutely
42 critical, and Commissioner Allen referred to earlier today,
43 is voice: the voice of LGBTIQ+ people in the design of
44 services across our leadership structures. We need to have
45 people in decision-making rooms who have lived experience
46 so that we can ensure that those lived experiences are
47 guiding us through the expertise that they provide.

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. We 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

1 conversations in mental health care models as well as
2 conversations about symptoms and treatment and other
3 holistic models that we might use as well.
4
5 And advocacy, as I sort of spoke to earlier, I think
6 it would be wonderful to see the mental health system more
7 broadly consider the role of advocacy for addressing
8 discrimination and its inter-relationship with poorer
9 mental health. So, Safe Schools has been mentioned several
10 times today: I would say that's the starting process in
11 terms of better mental health outcomes. Also addressing
12 where there is discrimination in workplaces and the kinds
13 of conversations that we have in our community and more
14 broadly in our society around LGBTIQ+ experiences because,
15 as we've heard several times, they continue to impact on
16 the mental health of LGBTIQ+ people in communities
17
18 MS COGHLAN: Thank you Ms Larsen. Chair, do the
19 Commissioners have any questions?
20
21 COMMISSIONER FELS: Q. I have one short one. The role
22 of families and carers in this situation, often we've heard
23 in other parts of this inquiry quite a lot about their
24 role, their contribution: slightly less about that today.
25 Is there any reason for that, or is their role a bit less
26 perhaps than in other areas of mental health?
27 A. Oh, no, I don't think so. I think possibly what -
28 this is my own sort of speculation a little bit - possibly
29 what's happened is that we're possibly having discussions
30 in a little bit of a siloed way again. So, we're talking
31 about LGBTIQ+ people today so therefore we're talking about
32 LGBTIQ+ people, but absolutely families and carers are
33 critical.
34
35 I think in the mental health system and in the health
36 system more broadly what we have had is a history of
37 families and carers, particularly where they might be
38 partners or other forms of relationships and queer
39 relationships, not necessarily being acknowledged. So, I
40 think it's an absolutely critical area, both in recognising
41 and not making assumptions about who people are in LGBTIQ+
42 people's lives, and also thinking about families of choice
43 which, for many people responding to questions and forms
44 like next of kin and those kinds of questions can be
45 challenging, because they might look quite different for
46 people who have families of choice rather than still
47 remaining connected to their family of origin

1
2 COMMISSIONER FELS: Thank you.
3
4 CHAIR: Q. Thank you very much. I just have one other
5 question I'd like to ask, it's in relation to - and we
6 heard this morning from Commissioner Allen for the need for
7 many LGBTIQ+ people to be hypervigilant, to be aware of the
8 environment in which they are for their own personal safety
9 and wellbeing. In your statement you also talk about the
10 challenge of bed-based services and the need for people to
11 feel both physically and sexually safe.
12
13 When you think about that, through this Royal
14 Commission we've heard already about how challenged those
15 environments can be, and when you think about what the
16 design of bed-based services should be into the future -
17 and I'm conscious that Mind itself provides a number of
18 bed-based services, including PARCs - have you got some
19 thoughts of what needs to be built in to really make sure
20 that, where that need is there and someone must access a
21 bed-based service, they are able to feel safe, both
22 physically and sexually?
23 A. So I won't talk to the actual structures of the
24 buildings, I don't have a strong service delivery
25 background, so I think I would be stepping into a space
26 that I'm not the best person to answer that question, but I
27 would say that there's probably two elements: one is, while
28 we have a broader mainstream system that is regularly not
29 meeting the needs of people who are particularly trans and
30 gender diverse, then we do need to think about LGBTIQ+
31 specific bed-based environments in the interim where that's
32 not available or, more broadly, then it is really about
33 having probably an advanced level of training as a minimum
34 requirement for staff: not only for staff to be inclusive,
35 but also to think about how they create environments that
36 are safe by working with the other clients that are
37 potentially accessing the bed-based service, because it's
38 both. So, I think that would be the place to start.
39
40 Q. Thank you. There's one other point I just wanted to
41 take up which is the discussion about the ability to
42 maintain a financially sustainable service. You describe
43 that at the Equality Centre 85 per cent of your clients
44 have a difficulty paying the gap.
45 A. M'hmm.
46
47 Q. I guess we've also heard a lot at this Royal

1 Commission about whether 10 sessions even on their own are
2 sufficient. What do you find in terms of the work that you
3 do at the Equality Centre about whether those 10 sessions
4 is all that's needed, or how do you supplement that if
5 no-one has a capacity to pay?
6 A. So again, I won't - I'll take that on notice in terms
7 of how we always supplement that, but from my discussions
8 with the staff at the Equality Centre, I certainly know
9 that the 10 sessions are not enough, and therefore it can
10 create a barrier, or it creates a difficulty for us in
11 terms of how we allow that person to access the service.
12
13 CHAIR: Thank you. Thank you very much.
14
15 MS COGHLAN: Thank you. May Ms Larsen be excused?
16
17 CHAIR: Yes, thank you very much for your statement and
18 evidence today.
19
20 **<THE WITNESS WITHDREW**
21
22 MS COGHLAN: The next witness I propose to call, their
23 evidence is the subject of a non-publication order, and
24 they will be giving evidence in the name of a pseudonym.
25 Chair, will the terms of that order be read now?
26
27 CHAIR: Yes, thank you.
28
29 Pursuant to the Inquiries Act 2014, the Royal
30 Commission has made an order prohibiting the publication of
31 any information that might identify the next witness.
32
33 A copy of that order has been placed next to the door
34 of the hearing room. Throughout the hearing today the
35 witness will be referred to as the pseudonym "Alex Smith".
36
37 I would like to remind all persons present including
38 the media that any material which will enable the
39 identification of this witness cannot be published.
40
41 The hearing of Alex Smith's evidence will be limited
42 to those people attending today's hearing. For those
43 watching on the live stream, this portion of the hearing
44 today will not be broadcasted. I ask that the live stream
45 now be cut.
46
47 MS COGHLAN: Thank you, Chair.

1
2 (Live stream cut.)
3
4 MS COGHLAN: I call Alex Smith.
5
6 <**ALEX SMITH, affirmed and examined: [2.36pm]**
7
8 MS COGHLAN: Q. Alex, you've made a statement with the
9 assistance of the Commission staff?
10 A. Yes.
11
12 Q. I tender that statement. [WIT.0001.0021.0001.]
13 You were born in England and grew up in Western
14 Australia?
15 A. Yes, that's correct.
16
17 Q. You moved to Melbourne in 2004?
18 A. Yes.
19
20 Q. How old were you then?
21 A. 24 - 23, 24, yeah.
22
23 Q. Can I ask you how you identify?
24 A. I now identify as a trans masculine person, so I've
25 medically transitioned, was assigned female at birth.
26
27 Q. There has been, over the course of particularly your
28 20s, sort of a change in how you have identified?
29 A. Yes. So, when I first moved to Melbourne I identified
30 as a lesbian female, you know. As a small child I probably
31 did identify more as transgender, but yeah, in my 20s I
32 identified as lesbian. In my later 20s, I identified as a
33 non-binary person, and since I've begun my journey of
34 medical transitioning, I now identify as a trans masculine
35 person and use he/him or they/them pronouns.
36
37 Q. Can I ask you about your first interaction with the
38 Victorian mental health system?
39 A. Yes, that would have been when I was around 25, I was
40 admitted to an Emergency Department in a large metropolitan
41 hospital. As a result of a self-harming incident I
42 required a number of stitches all up my arm, and I had,
43 yeah, not a great experience when I went into the ED
44 Department. They said to me that I was silly and that I
45 shouldn't do things like this, and that I was taking up a
46 bed that could otherwise be used for somebody who was sick.
47 And, I wasn't, like, provided with any referrals to the

1 mental health service or provided any follow-up care, other
2 than getting my stitches out at my GP, and that person also
3 didn't ask me if I wanted to see somebody or anything like
4 that.
5
6 Q. So, on your own, after that time you signed up for
7 counselling provided by an LGBT-specific health service?
8 A. Yes. I found that there was a service online that
9 catered mainly to the gay male community at that time, but
10 was prepared to accept female identifying people, and yeah,
11 I accessed that service at that time and had some sessions
12 with them.
13
14 Q. When you first contacted that service, and I'll just
15 read this from your statement and ask you to comment on it,
16 you say:
17
18 "I remember feeling pressure to be
19 performative about how unwell and volatile
20 I was so to increase my chances of getting
21 help."
22
23 Can you just explain that?
24 A. I think that all of us in the LGBTQI community know
25 that mental health services that cater specifically to our
26 community are badly resourced, and that there's always a
27 wait list and that, in order to access care when you need
28 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
30 lay it on thick about how difficult things are for you,
31 which I think - you know, I understand that people - that
32 there's a list and that people need to be triaged into a
33 level of urgency, but I think that the lack of resources
34 create a situation where there's an incentive for people to
35 be performative about how unwell they are because they know
36 that, if they don't do that, they'll be bumped down to the
37 bottom of the waiting list.
38
39 So, for people that are trying to practice resilience
40 and a strength-based approach to their life in an every day
41 situation, that can mean that they're less likely to be
42 able to access services in a timely fashion, which is a
43 shame.
44
45 Q. You ended up attending around 16 counselling sessions
46 with that service?
47 A. Yes.

1
2 Q. But you found, given the way the structure or the
3 counselling service operated, that it was - you would see
4 different counsellors?
5 A. Yeah, my understanding is that the people that I was
6 seeing at the time were people, like, who are Masters
7 students doing their studies at a Uni and were doing a
8 placement with this health service. So, you know, while
9 they were all lovely, caring and compassionate people, they
10 would - like, their placement would end and then you would
11 be, you know, like handed over to a new Masters student who
12 would also be completing their rotation: so there was a
13 lack of continuity of care, perhaps a lack of clinical
14 expertise because they weren't - you know, they were at the
15 beginning of their careers rather than in the middle of
16 them.
17
18 And yeah, I found it really emotionally draining for
19 that to happen and, when one of my counsellors came to the
20 end of their placement I decided not to go back there
21 because I couldn't - yeah, I just didn't feel like I could
22 start again with another person.
23
24 Q. Can I ask you about a period of time in 2010 when you
25 were working as a public servant and you contacted the
26 Employee Assistance Program: can you just tell the
27 Commissioners about that?
28 A. Yes. Yeah, I was working for a large institution at
29 that time and they, like many organisations, had an
30 Employee Assistance Program that you can call up to make an
31 appointment for counselling. I did that with the service
32 and had a meeting with them and expressed to them that I
33 was having significant difficulties at work because I felt
34 really uncomfortable using the female toilets, and that I
35 didn't wanna use the men's toilets either, and that - yeah,
36 I just felt like it was a really difficult part of my every
37 day and that, you know, I'd be running around to try and
38 find a disabled toilet, which is not ideal either, and the
39 Employee Assistance Program counsellor or psychologist said
40 that that was something that they couldn't help me with,
41 they didn't know anything about that, and they didn't offer
42 me, like, a referral to anywhere else either.
43
44 So, I didn't speak to anybody, like a mental health
45 service or anything like that about my gender-related
46 issues for many years after that because I felt really
47 embarrassed and upset about how that went.

1
2 Q. Soon after that, you moved to New South Wales for work
3 and then to the Northern Territory, and returned to
4 Victoria in 2016, in regional Victoria, a large regional
5 Victorian town. There was a point in time where you felt
6 the need to access services, and so, what did you do about
7 it?
8 A. Yeah, well, that was a bit of a difficult situation
9 because at that time I identified as non-binary, I was
10 going through a process of assisted reproductive treatment
11 with my partner at the time, which was a queer
12 relationship, and I was having a very difficult time at
13 work and in my personal life, so I wanted to access
14 counselling support but I felt that, if I went to anywhere
15 in the country town that I was living in, that, you know,
16 best case scenario they'd be, like, "How curious, tell me
17 about all this stuff", and maybe I would be able to speak
18 to somebody, but I wouldn't be able to speak to anybody who
19 had any, like, knowledge or competency about my life, about
20 my relationship decisions.
21
22 And I was worried that, by going to a country-based
23 service and presenting as somebody who was non-binary, that
24 they would consider that in and of itself a part of a
25 mental health concern that I had, and that I would be
26 subject to either, you know, intentional or unintentional
27 stigma and discrimination, so I didn't see anybody in the
28 country town.
29
30 I contacted a service in Melbourne which was a couple
31 of hundred Ks away and attempted to get on the wait list
32 for services there. I did the intake process and things
33 like that, and I asked if there was any possibility that I
34 could speak to somebody either after hours when I got home
35 from work, which was about 6 o'clock, and do a
36 telephone-based appointment, or if I could come into
37 Melbourne on a Saturday or a Sunday, because I was working
38 full-time at that time, to see somebody.
39
40 Yeah, and it was quite a long time until I was able to
41 access services - this is many, many, many weeks - and
42 yeah, I wasn't able to access the service in a way that
43 worked for me. I had to essentially leave work so that I
44 could speak to the person who was available to talk to me
45 on the telephone: like, I would sit in my car, because it
46 was half an hour to get home and I couldn't - so I just
47 ended up having to do the telephone counselling in my car,

1 basically parked next to the train station in this country
2 town, yeah, which wasn't ideal.
3
4 Q. One of the things you say in your statement is that
5 the telephone counselling you did get was too little, too
6 late, because you had to wait so long.
7 A. Yeah. I was going through the assisted reproductive
8 treatment stuff at that time, and I was in a relationship
9 with my partner at that time, and we had to make a really
10 difficult decision around whether or not to continue with
11 IVF treatment or not, and I felt like I was not
12 psychologically stable enough at that point to make a good
13 choice, and I'm not sure that I did make the best choice,
14 and I certainly really hurt my then partner a lot
15 throughout that process by behaving poorly, with a lack of
16 insight, respect, and yeah, I think I was really struggling
17 with gender identity-related issues.
18
19 You know, going through IVF while identifying as a
20 non-binary person is extremely emotionally challenging, and
21 also medically challenging, and not having any
22 psychological support at that time, I think, yeah, really
23 impacted on me and I think it really impacted very
24 detrimentally on my relationship at that time which then
25 came to an end.
26
27 Q. Can I ask you about March 2018 and getting support to
28 transition and what was available, if any services, at that
29 time?
30 A. Yes. So, I had increasingly decided that I wanted to
31 start medically transitioning with hormone replacement
32 therapy, and I was extremely concerned about losing my
33 family through the process, who I have a strained
34 relationship with already. So, I really wanted to access
35 some mental health support, and I was working full-time as
36 I had done throughout this period.
37
38 I called up a LGBTQI service and they let me know that
39 there would be a long wait list. I was referred into a
40 service that didn't have a long wait list, but that I'd
41 have to pay, you know, like the gap payment on a mental
42 health plan, which I was able to do at that time because I
43 was working. That was, yeah, like, really fantastic being
44 able to access a LGBTQI-specific mental health service at
45 that time where I didn't feel like I would have to explain
46 the basics of, you know, what transgender is, what hormone
47 replacement therapy is, what that would mean for somebody's

1 emotional health or that they would have some competency
2 around the basics of trans and gender diverse health care,
3 so yeah, that was good.
4
5 Q. You saw a clinical psychologist at that service?
6 A. Yes.
7
8 Q. And, although you were grateful for that, it wasn't
9 the right fit for you?
10 A. Yes. The particular counsellor I didn't feel was a
11 great fit for me, because he was a cisgendered male, and at
12 that time, yeah, because of the nature of my transition I
13 felt like it was really difficult to talk to a person with
14 that identity about my body and my life, and it just felt
15 really uncomfortable and it made it harder for me to
16 disclose things that would probably be useful to disclose
17 while accessing mental health support.
18
19 But I was very much aware that, you know, he was
20 really one of the only available people in Victoria who I
21 felt would understand the basics of my situation and was
22 also one of the only people that was able to write what I
23 call the WPATH letters, which is the letters that you need
24 to get gender-affirming surgery, so I wanted to stick with
25 that person for that reason.
26
27 Q. Ultimately, you stopped seeing that psychologist, in
28 part, because you couldn't afford to continue?
29 A. Yes. So, once I made the decision for hormone
30 replacement therapy I also wanted to have chest surgery,
31 which is very expensive, it's not available under Medicare,
32 it's classed as elective cosmetic surgery, and it costs
33 about $10,500 to have that surgery, so I didn't feel that I
34 could pay for mental health support with that counsellor
35 while saving for surgery because it was obviously quite
36 expensive.
37
38 Q. You talked about some telephone counselling that you
39 had previously. You ended up reconnecting with that
40 service for the purposes of having some counselling with
41 your partner.
42 A. Yes. I was having an extremely difficult time. I
43 think that within the first year, certainly within the
44 first six months of your decision to transition and to come
45 out to, you know, your entire extended workforce,
46 community, friends, friends of friends, and your family,
47 it's extremely - for me it was an extremely difficult time

1 and I ended my relationship with my immediate family except
2 for my mother, so it was a very difficult time and that had
3 a really big impact on my relationship with my new partner.
4
5 I mean, she, to be honest, was basically doing all the
6 mental health care work for me, which wasn't good for her
7 and it wasn't good for our relationship. So, we really
8 wanted to access - she really wanted to access relationship
9 counselling and I really didn't wanna go to, like, a
10 mainstream couples counsellor, because I just felt like I
11 didn't wanna have to talk to that person about what being
12 trans meant on top of having to have a really awkward
13 interaction about my relationship.
14
15 So, I wanted to go back to the LGBTQI-specific
16 service, but yeah, it took an extremely, extremely long
17 time to get to see a counsellor and yeah, again, it was
18 very much that process that you have to call up - and my
19 partner was calling up, you know, crying on the telephone
20 asking when we're gonna get to see somebody. She was
21 really worried that our relationship was going to come to
22 an end and that, you know, like, if it was going to, at
23 least we could talk through things first. Yeah, so it was
24 really a very, very difficult time for me and I think I
25 probably did the most acute part of the transition, like,
26 the first three months in the workforce without any mental
27 health care support.
28
29 Q. Eventually, you were connected as a couple with a
30 counsellor, but that turned out to be the same person who
31 had previously provided you individual telephone
32 counselling.
33 A. Yes, that's right. That person was somebody who was
34 part of the LGBTQI community and identified as gender
35 diverse, so I think it was felt by the service that they
36 would be a good fit.
37
38 For us, I don't think that they were the best fit. I
39 think, like, it's hard for anybody to find a counsellor or
40 a psychologist that is a good fit and I think that, when
41 you're trying to find a good fit in an extremely - you
42 know, in a very - you know, with a service that has no
43 resources, and that there are hardly any people around, you
44 kind of don't really get heaps of choice, and that, if you
45 decide to stop seeing somebody, you know that that's gonna
46 mean that you're gonna be on a wait list for, you know,
47 three to six months somewhere else, so I decided to stick

1 with that person for some time, and we definitely made the
2 best of it.
3
4 Q. Can I ask you about some privacy concerns you had
5 around that time and you say this in your statement:
6
7 "At the time when my partner and I were
8 accessing couples counselling it dawned on
9 me that a lot of my workplace colleagues
10 were friends or had professional
11 relationships with my couples counsellor
12 and individual counsellor."
13
14 So, that was a realisation you had at that time?
15 A. Yes. I think the LGBTIQ service sector is a small
16 sector, everybody knows each other or, you know, has
17 professional relationships in one way or another, and I
18 think that it is hard to access appropriate, inclusive,
19 specialist mental health support without, yeah, feeling
20 very much like your privacy might be compromised.
21
22 And yeah, I became worried about, you know, how many
23 people for example would have access to my clinical file,
24 what the processes were around whether there would be an
25 alert if somebody else accessed my file, where the file was
26 kept: yeah, I became really worried that just sort of
27 anybody could read my case history if they wanted to. And,
28 you know, that stuff I don't feel was particularly well set
29 out, so yeah, I decided that that was becoming more of a
30 barrier to me than of benefit at that point.
31
32 Q. You later on decided to seek assistance through the
33 private system?
34 A. Yes, I decided that - you know, because I was
35 concerned about the close-knit nature of the LGBTIQ mental
36 health system, that it would just be better for me to go to
37 somebody else that might not know anything about trans or
38 gender diverse issues, or at least didn't know anyone that
39 I knew and wasn't gonna talk to anybody about my life and,
40 you know, the person that I did see who was recommended
41 through an acquaintance was really good, but like, when it
42 came to the end of the session, they let me know that you
43 couldn't use a mental health care plan for that kind of
44 therapy, and so, yeah, I had to pay I think it was like
45 $145 for the session, which, you know, under other
46 circumstances I probably would have had the capacity to pay
47 because I do work full-time, but I've just been through

1 chest surgery which, as I mentioned, is very costly, and I
2 also had to take a significant amount of time off work, so
3 I just couldn't afford to pay for that because I'm already
4 trying to pay off debt related to my medical transition.
5 So, yeah, that's what happened with that.
6
7 Q. Can you tell the Commissioners about your experience
8 with online counselling services?
9 A. Yeah, I think that online counselling services is a
10 really good idea. It's just that, the two times that I
11 attempted to access them, I couldn't get through to
12 anybody. Like, I had - yeah, it was on my telephone and
13 you would just wait to connect to a counsellor to join the
14 chatroom or whatever it is, and yeah, nobody connected.
15 So, like on neither of those occasions was I able to get
16 any support, which I actually think would have been a
17 pretty good fit for me because, you know, I have a concern
18 about my privacy, so the idea of being able to access an
19 anonymous service would have been good. And I do think
20 they're good, I just couldn't access it.
21
22 Q. You refer in your statement to accessing online peer
23 support via a Facebook group: can you just talk about that?
24 A. Yeah. So, a transgender and gender diverse
25 organisation in Victoria runs a really, like, wonderful
26 online Facebook group called The Shed, which is for trans
27 masculine people, people assigned female at birth who are
28 non-binary or transitioning to a male identity. That was
29 an amazingly important resource for me.
30
31 It was so encouraging to see people that looked like
32 me that were going through the same dilemmas, were having
33 the same weird and at times humorous things happen. You
34 know, to see photos that people would generously share of
35 their, like, chest surgery for example; people talking
36 about the cost of health care and different private health
37 insurance companies and how to access gender affirming care
38 under them.
39
40 I really couldn't have continued with work, I think,
41 without having that online Facebook group. I was a bit of
42 a, like, lurker on that group: I didn't really spend much
43 time posting on it or asking questions, but just to be able
44 to see people going through the same thing was of immense
45 personal support to me, and knowing that there was somebody
46 at the trans and gender diverse organisation that was
47 volunteering their time to moderate it and to make it work,

1 yeah, I was immensely grateful for.
2
3 I hope that one day people like that can be given the
4 resources and support and recognition that they deserve,
5 because they really are saving people's lives and they're
6 saving people's careers and relationships, so that was
7 incredibly important.
8
9 Q. Can I ask you about the recommendations that you would
10 make to improve the mental health system starting with a
11 publicly accessible database?
12 A. I think that, if there was a database of some kind, or
13 even one that I could access through a referral, that
14 clearly stated that there were a bunch of different mental
15 health practitioners in different areas who had either done
16 LGBTIQ-inclusive training, including trans awareness
17 training, that would be immensely helpful.
18
19 Because, you know, at the moment you're extremely
20 reliant upon, I guess, word-of-mouth. Particularly in
21 rural and regional areas, I'm just not sure that such a
22 thing does exist, but if there was a resource that was
23 created where there would be gaps, then at least we could
24 start to address those gaps and ask people to opt in and
25 maybe ask them if they wanted to undergo training and
26 become a specialist or, you know, an advocate for further
27 services in their area.
28
29 Q. Just picking up something you raised about trans
30 awareness training: you see that as particularly important
31 as compared with having just an awareness of a gay or
32 lesbian client.
33 A. Yeah, I mean, I think that an awareness of gay,
34 lesbian and bisexual issues is extremely important as well,
35 because obviously trans and gender diverse people have all
36 different kinds of sexualities, but I do think that it's
37 fair to say that there's probably less stigma and
38 discrimination and a greater awareness and appreciation of
39 the contributions of gay and lesbian and bisexual people.
40
41 I think that there's still a very low level of
42 awareness or understanding of trans and gender diverse
43 issues, and I think that it's the kind of issue that most -
44 many, if not most, general practitioners and mental health
45 practitioners think, I don't know how to deal with that and
46 I'm scared of getting it wrong so I don't wanna try. And
47 so, I think that any inclusive practice training program

1 needs to focus on trans and gender diverse issues because
2 we have different issues.
3
4 For example, if you do decide to access hormones, you
5 know, going through a second puberty as I did is a pretty
6 specific situation that comes with its own mental health
7 challenges. You know, the grief around parental and
8 familial rejection around trans and gender diverse identity
9 is quite specific; having some knowledge about surgery,
10 desire for surgery, and an awareness of the fact that there
11 isn't, like, publicly accessible surgery available and the
12 dilemma that that puts people in.
13
14 Certainly, the lack of access to bottom surgery in
15 Australia: there's only one surgeon that provides that kind
16 of surgery and it costs, you know, almost $100,000. So,
17 having people that understand and that you don't have to
18 educate about those issues and that that's the struggle
19 that you're carrying with you when you come in to see
20 somebody, would be really helpful.
21
22 Q. One of the themes that you've mentioned in your
23 evidence is about privacy management, and you would like to
24 see more professional practices around the protection of
25 privacy. Can I move on to ask you about the number of
26 mental health sessions provided under a mental health plan?
27 A. Yes. Well, my understanding is that you get your six
28 initial sessions and you can go back to get an additional
29 four sessions if you speak to your GP about it.
30
31 So, for me as a trans and gender diverse person, the
32 idea that you could have 10 sessions and be sorted with
33 your transition is absurd. You know, really I think that
34 most people going through, particularly that first year of
35 transitioning, should be I think entitled to one-on-one
36 counselling support at least fortnightly I would have
37 thought, and you would exhaust your entitlements under the
38 Medicare scheme within two and a half months if that was
39 the case.
40
41 I think particularly because there's a current legal
42 requirement for you to engage with a clinical psychiatrist
43 or psychologist in order to get the WPATH letters so that
44 you could undergo affirming surgery such as the chest
45 surgery that I had, I think it should be an obligation
46 that, if government is putting that requirement in front of
47 us, then I believe that we should be entitled to accessing

1 free or low cost mental health support so that we can
2 actually get those letters so that we can engage with
3 medical practitioners to get the gender-affirming surgeries
4 that we need.
5
6 Q. Just finally, can I ask you about peer support
7 services?
8 A. Yeah, so the peer support service that I suppose I
9 informally had a relationship with was The Shed which I
10 mentioned, which was the Facebook group. They also do,
11 like, they organise camps and have meetings and things like
12 that, and they're an absolutely crucial part of the - maybe
13 not a formal part of the mental health system, but it
14 should be, and the fact of the matter is that at the moment
15 most of those people that do that kind of work are doing it
16 on a volunteer basis, often who have been through
17 incredible struggles in their own life and know how
18 difficult it is, and so want to volunteer their time to
19 support people in the same situation as them.
20
21 I think that those community organisations should be
22 resourced and that, whether that's financial resources so
23 that they can be paid for the work they do, or whether it's
24 so they can access mental health care support, because
25 certainly sometimes people in those roles are the first
26 responders to an acute - you know, disclosures, mental
27 health crises, disclosures around difficult sexual assaults
28 and things like that, all the difficult things that people
29 go through in life, and particularly for trans and gender
30 diverse people that may be struggling with their identity,
31 people like that are absolutely diamonds that volunteer
32 their time to look after other people, and I think that
33 they should be given access to mental health care support
34 as well while they're doing that kind of peer support.
35
36 MS COGHLAN: Thank you Alex. Chair, do the Commissioners
37 have any questions?
38
39 CHAIR: Q. I just have one. Thank you very much, Alex,
40 for your material today and for being so willing to share
41 with us your journey in your statement.
42
43 You made a point in your statement that reminds us of
44 the need to think about who we need to educate and inform
45 about transgender issues, because you said at one point in
46 your journey you were refused service by a pharmacist in
47 central Melbourne as they did not wish to provide HRT.

1
2 When you're thinking about this inclusive program of making
3 sure that discriminatory practices aren't there, I think
4 that was a very important reminder for us, so that's a
5 broader group of people. Do you want to add anything to
6 that?
7 A. Yes, I was listening to Dr Telfer's wonderful evidence
8 about the youth-based service, and it really did bring a
9 tear to my eye to think about how much of a difference that
10 would have made to somebody like me if there were, like, an
11 adult version of that where you could go somewhere and see
12 a psychologist, where you could get your HRT prescription
13 somewhere that you knew was gonna be safe and inclusive.
14 It would make such a difference to have allied health
15 services and pharmacy services under one roof, or at least
16 under a few roofs that we all knew about.
17
18 At the moment there's nothing like that: you look on a
19 Facebook group like The Shed and ask people, you know,
20 "Have you been to a pharmacist and, if so, how were you
21 treated?" And you try and follow the good tip, but it's
22 always dependent on who's working at the front counter.
23
24 Yeah, it was incredibly difficult for me getting my
25 first script of HRT, it was incredibly upsetting to be
26 refused service. It was absolutely humiliating, it
27 happened about a hundred metres away from my workplace. I
28 had to go back into work, I didn't know what to do, I
29 didn't know where to go. Yeah, it was absolutely
30 humiliating, so yeah, if we could have a kind of
31 multidisciplinary approach to care, that would be an
32 amazing improvement on the current situation.
33
34 CHAIR: Thank you very much, Alex, and again, thank you
35 for having the courage to come and share with us today,
36 it's been very helpful.
37
38 MS COGHLAN: Thank you. May Alex be excused, please?
39
40 CHAIR: Yes, please.
41
42 <**THE WITNESS WITHDREW**
43
44 MS COGHLAN: Thank you, Chair, and Commissioners, that
45 concludes the evidence for today.
46
47 **AT 3.15PM THE COMMISSION WAS ADJOURNED TO**

1 **THURSDAY, 18 JULY 2019 AT 10.00AM**
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## $

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