HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

STANDING COMMITTEE

ON

HEALTH

Tuesday, October 11, 2022

LEGISLATIVE CHAMBER

Gender Affirming Care

Printed and Published by Nova Scotia Hansard Reporting Services

HEALTH COMMITTEE

Trevor Boudreau (Chair)
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Hon. Brendan Maguire
Rafah DiCostanzo
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Susan Leblanc

[Kent Smith was replaced by Nolan Young.]
[Gary Burrill was replaced by Lisa Lachance.]

In Attendance:

Sherri Mitchell
Acting Legislative Committee Clerk

Gordon Hebb
Legislative Counsel

WITNESSES

Gender Affirming Care Nova Scotia
Riley Nielson Baker
Director

Cape Breton Transgender Network
Veronica Merryfield
Founder

Department of Health and Wellness
Tanya Penney
Senior Director Executive Director, Clinical

Office of Addictions and Mental Health
Dr. Samuel Hickcox
Chief Officer

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, OCTOBER 11, 2022

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Trevor Boudreau

VICE CHAIR
Nolan Young

THE CHAIR: Order. We'll call this meeting to order. It is 1:01 p.m. This is the Standing Committee on Health. My name is Trevor Boudreau. I am the MLA for Richmond and Chair of the committee.

Today we'll be hearing from witnesses regarding gender-affirming care. I'll ask all members here and witnesses to please put your phones on silent so that they don't interrupt.

What we'll do to start off is we'll introduce committee members, but I'd also like to recognize the new committee member to the Health Committee, the Honourable Brendan Maguire for the Liberal caucus.

With that being said, I'll start with MLA Lachance, and we can introduce the members of the committee.

[The members introduced themselves.]

THE CHAIR: As I said before, today's topic is gender-affirming care. We have a number of witnesses with us today, and I'll get the witnesses to introduce themselves, starting with Mx. Nielson Baker.

[The witnesses introduced themselves.]

THE CHAIR: At this time, we'll ask the witnesses if they have any opening remarks, starting with Mx. Nielson Baker.

RILEY NIELSON BAKER: Lead or follow is the question that we are dealing with today in distilling the conversations about gender-affirming care. We are the most trans province per capita in Canada and the second most trans city in Canada. The reality is the changes that we're going to talk about today are going to come no matter what.

We should be leading as the most trans province in these issues. There is no reason that we're being outpaced by other provinces that have a much smaller percentage of their population identifying as members of our community.

We must reflect that this system of gender-affirming care in Nova Scotia was never designed to work. From the beginning, it was never designed to fully address what we need here in this province. We've had more than 10 years to address these problems and make changes, and we have only seen three major changes in the last decade.

We know the benefit of making these changes. We know the consequences of not making them. We have run out of time to address these issues. We've waited 10 years, and in that time people have died, people have suffered unnecessarily, and people have gone into life-crushing debt unnecessarily.

If we want to do what's best for our communities and what is best for our province, we need to do more and we need to work faster than what we currently are on gender-affirming care.

THE CHAIR: Thank you. Ms. Penney.

TANYA PENNEY: Good afternoon, Mr. Chair, members of the committee, and folks in the gallery - I really do feel like my back is to you, and so I apologize for that in advance.

Thank you for allowing us the opportunity to meet with you today to engage in this very meaningful conversation and discussion. On behalf of Dr. Hickcox and myself, we're pleased to be here in the attendance with representatives from Gender Affirming Care Nova Scotia and the Cape Breton Transgender Network to answer your questions on gender-affirming care.

Before we turn it over to the committee members to begin with questions, I would like to give an overview of some of the important work my colleagues are doing to address some of the barriers to gender-affirming care. We all know that health is much more than physical well-being. Our mental health, sexual health, how we identify, the social determinants of health, social connectedness, all contribute to the overall well-being of Nova Scotians.

We are working hard to make meaningful changes to gender-affirming care in Nova Scotia, and in the Summer, we took some steps to remove some of those barriers for Nova Scotians who are seeking gender-affirming surgery and, in turn, helped cut those wait times. We've removed the need for a letter from a Nova Scotia specialist and a letter from a specialist confirming postoperative care - especially if that care is occurring in Nova Scotia. We've also allowed more health care providers to provide psychosocial assessments, which was previously only committed by mental health clinicians with specific training in gender-affirming care.

While we are very proud of the work we have done so far, we know there is still a lot more work to do to continue to support transgender and gender-diverse Nova Scotians who need access to gender-affirming care. We will continue to look for opportunities to collaborate with our partners and stakeholders to move this important work forward.

I want to thank the community groups, our partners, and advocates across the province for being a strong voice for Nova Scotians and continue an important dialogue on how we can collectively work together to improve how Nova Scotians access these services.

THE CHAIR: Thank you. Dr. Hickcox.

DR. SAMUEL HICKCOX: Thank you, Mr. Chair, and thank you committee members, as well as folks in the gallery. I want to acknowledge you and thank you for coming.

We know that inclusive and supportive gender-affirming care can have a profound impact on peoples' mental health and wellbeing. We recently made improvements to the gender-affirming surgery application process to make it easier and faster for people to receive the care they need. These changes were made in recognition of the unnecessary burden that people have been facing, a burden that was undoubtedly causing added stress and negatively impacting people's mental health.

The evidence clearly shows that transgender and gender-diverse people are more likely to experience mental health and addictions challenges than the general population, and that delays in accessing gender-affirming care can exacerbate these challenges.

The Office of Addictions and Mental Health was established to oversee the delivery of mental health and addictions care and to contribute to the development of a Nova Scotia in which people are more mentally healthy. This is critically important work, and I assure you that we are committed to making the changes needed to provide the care that Nova Scotians so rightly deserves, and this includes work to address stigma. It also includes offering more responsive care that recognizes the unique needs of Nova Scotians - including those from transgender and gender-diverse communities.

We welcome discussions, like those we're having here today, where we can speak to the work we're doing. We also welcome opportunities to further engage with representatives and advocates from the transgender and gender diverse communities in our province to gain a better understanding of where there are gaps, where the needs are greatest, and how we can further reduce barriers. We're committed to working with these communities to get this right.

I'll turn it back to you, Mr. Chair.

THE CHAIR: Thank you. Finally, Ms. Merryfield.

VERONICA MERRYFIELD: Thank you, Mr. Chair, and thank you to the committee. It's nice to see folks behind me.

I hope the committee will grant me some latitude here. I wanted to keep this short, but dyslexia makes reading aloud challenging. In an effort to keep short what could be a very long story, I've written this out, so it might be a bit stilted.

I was assigned male at birth - although, as I found out later in life a few years ago, this assignment came after infant surgery. I was born intersex. Etched in my memory is the moment as a 4-year-old that I realized that I was female, being treated as male. I asked for help as an 8-year-old. I was told that God doesn't make mistakes, followed by a long religious lecture.

In my teens I ran away from home, evading authorities for nearly a week; attempted suicide; survived with immersion in schoolwork, music, and learning electronics because of music. Despite my efforts in many libraries to find answers, I did not know that what I was experiencing had a name - gender dysphoria - nor that help was available, albeit in some infancy at the time. I sometimes think I might have avoided the various barbaric treatments, such as electroshock treatment, that were common at the time.

It was only through a documentary about Julia Grant's journey that I happened across whilst I was babysitting that I found the name and some language. A subsequent library trip revealed much. Exposure to language is why education is so important from a young age.

After my electronics engineering degree, I tried to get help to get by in life. After another suicide attempt, I sought help. One consult with a psychiatrist expert and I had a diagnosis, and I got hormones. Within a short time, I was starting to feel so much better.

And thus started my transition journey: electrolysis, name change, voice therapy, and surgery, wherein the intersex was first, to me, discovered. That was nearly 30 years ago. For that part of my journey, I used a mix of private services and public health care, because that's what was available and what wasn't, and some of the terrifying gatekeeping

that was happening at the time, not to mention the very long wait times. I know I was privileged to be able to do that.

Over the last 30 years, I've lived and worked in Cambridge, England; briefly in Guanshan, Taiwan; Tel Aviv in Israel; Port Alberni in Vancouver Island, where I moved in 2004; Chilliwack; and now Cape Breton, where I moved in 2016. In each location I've been a significant part of the local support community or have started it. In Cape Breton, I'm on the board of Pride and a few non-profits.

I've lost count of how many people I have helped and advocated for, how many teaching and education sessions I have spoken at, and how much abuse I've faced, both physically and verbally. But I remember well the two counts of sexual abuse.

I founded the Cape Breton Transgender Network to add visibility to what I was already doing. People were being referred to me from other organizations, so it was clear that they were searching, and they definitely needed help.

I provide support individually to adults, families, and youth; hold workshops at GSA conferences; teach equity, diversity, and inclusion to organizations including Marine Atlantic, the Canadian Coast Guard, and through the Cape Breton Partnership. Next month I do my first session of teaching at the Nova Scotia Health Authority. In the past, I've given training to suicide hotline workers, to medical professionals, support workers, and other organizations. I also provide help to those in other provinces and countries.

Support efforts range from someone to talk to who gets it, to help come to terms with it, to talk through the PTSD-like effects in a safe environment, help deal with the societal shame, help navigate the systems, attend appointments as an advocate, give and show how to give testosterone injections, explain things to parents and answer questions, advocate to get housing and get benefits, to do the first shopping trips, filing complaints on behalf of people, running support groups, et cetera, and even going with them to surgery in Montreal. This is all a volunteer effort.

From doing my first GSA in 2016, it was obvious that there was a shortcoming in the Children and Family Services Act. After finding various people in the system to talk with, I made efforts to get the bill changed to close the gap. The October 2020 version of the Act reflects this considerable effort.

I want to acknowledge the help that Marc Botte provided in getting this work in front of the then-minister, Kelly Regan, and the help that Kendra Coombes and Karla MacFarlane have given me over the years. At the 2019 GSA conference, I sat in on a student-organized and -led workshop on surviving hostile homes - one of the many heartbreaking things I've done. I'm glad the bill has changed, but there's still a lot of work that needs doing to avoid another heart-wrenching workshop.

[1:15 p.m.]

I'm frequently told that "stay in the lane" applies when dealing with various government departments. The silofication of government policy has a detrimental effect on many communities. It certainly affects the gender-diverse community. Many are in housing crisis. After they are 16, if they live at home and haven't grown out of the Children and Family Services Act, there is no protection from the human rights legislation. Many live in a very hostile environment. Many find they earn too little to afford housing and too much to qualify for housing support. The specifics of their health and mental health issues are effectively ignored unless they end up in a hospital, but even then, that was disappointingly little, if anything.

The disconnect between social services, housing, vital statistics, and health care means that an individual is having to fight on multiple fronts when they are least equipped to be able to do so. I have helped many to do this, and it's exhausting, frustrating, and soul-destroying, and my health is reasonably robust.

Riley and her then-co-author Dylan Thompson of the GACNS reached out to me in the last provincial election campaign right at the beginning on the policy surrounding sex care and some of the other issues faced by the gender-diverse community. Prior to that campaign, I had engaged Brian Comer on making some changes to the Nova Scotia Health Authority's gender-affirming care policy. He got me the first of many meetings with these two lovely people shortly after the election.

I am grateful for what has been achieved so far, but know there is more to come. I'm looking to getting that progress accelerated. The community is struggling. If it wasn't for Fiona, I would have met with the team last week, but I hope to be doing it this week. I haven't heard yet.

WPATH, the World Professional Association of Transgender Health, formerly the Harry Benjamin International Gender Dysphoria Association, recently released Version 8 of the Standards of Care, superseding the 2012 Version 7. As a side note, when I transitioned, it was the Harry Benjamin Standards of Care that were being used. In the terminology of the day, it was transsexual, not transgender. Much of the guidance in Version 8 has changed in line with what I and others have been advocating for.

While gender-affirming care resolves many of the mental issues faced by the gender-diverse community, there is much collateral, long-term damage and consequent issues. I mentioned earlier that my health is reasonably robust, but I do have long-term effects from the enforced closetification for many years, not to mention the devastating effects of growing up in a hostile home that involved conversion therapy - C-PTSD, anxiety, depression, imposter syndrome, to name a few. I'm also dyslexic and have ADHD, just to add to the fun, and I have some endocrine issues from the intersex condition.

Gender diversity costs many much. It shouldn't. The highest of these costs is suicide. In Cape Breton in the last few years, there have been several. The cost of family estrangement is all too common. Financially, things like wardrobe change is an expensive proposition. There are many expenses, many procedures considered cosmetic or elective that really aren't, and many medical costs that really should be covered by the health care policy that aren't. Many of these are the same today as they were for me 30 years ago.

It is way past time for us as a progressive society to invest robustly in our people. The last census showed this demographic to be a significant number, almost 1.5 per cent of our population. I think that's a lot. We must for the many, lift them from the drudgery of long-term disability and assistance, the perpetual dicing with suicide and survival, to be the productive, engaged, best selves, thriving members of our community.

THE CHAIR: Thank you, witnesses, for your opening remarks. We'll now get on to the questioning portion of the committee meeting today. Each of the caucuses gets 20 minutes of questioning to start. I may stop or interrupt right at the 20-minute time period, so if they're in the middle of a question, I do apologize. That's the way this committee works. After that, we'll figure out what the second period will be. It can be anywhere from seven to 10 minutes, depending on how much time we have left. Then we'll do committee business at the end. We'll give an opportunity for witnesses to have closing remarks as well.

With that being said, the Liberal caucus will begin. I see MLA Maguire has his hand up. MLA Maguire.

HON. BRENDAN MAGUIRE: I want to thank all of you for being here today. I particularly want to thank you, Veronica, for sharing your story. It's a very personal journey to get to where you are today, and I'm glad that you have the strength to tell it. A lot of people would not have that strength. I know there's a lot that you've overcome to get here. The fact that you tell that story and your personal experiences, I would imagine you've become a role model and an advocate for a lot of people. Thank you.

I guess I'll start with Veronica. When it comes to the Cape Breton Transgender Network - you're here on behalf of that network - what do you see as your organization's role in the state and status of gender-affirming care in Nova Scotia? I know it's kind of a broad question.

VERONICA MERRYFIELD: Yes, it is. It's a very broad question. Thank you for your words and sentiment. Yes, it is difficult to do this. Even though I've been doing it for nearly 30 years, telling that story over and over has a considerable emotional labour to do it. But there's a lot that it brings to everybody else in terms of the story and the perspective.

The work I do at the Cape Breton Transgender Network is twofold. One is the individual support that I do, and group support work. Out of that, I start to see patterns that

need to be addressed. I'm bringing that forward to various levels of government. It's about what those levels of government can do, and the priorities based on the difficulties that individuals are facing as they take this journey. That's kind of what I try to do.

BRENDAN MAGUIRE: Thank you for that answer. I guess if you had a magic wand or the ability to implement anything, what specific policies or areas on what the government can do for gender-affirming care, what would you change or what policies would you put in to make access and the whole process better and more accessible to Nova Scotians?

VERONICA MERRYFIELD: Do you realize how huge that is? (Laughter) The answer to that is enormous. If you're going to implement the whole of WPATH's Standards of Care 8 in its entirety - the policy document that Gender Affirming Care Nova Scotia has put forward - the abolition of costs involved with name changes at Statistics Canada, providing affordable housing, changing the rate of assistants in support care for those who need that, to change the rate of housing support. I mean, really, it's huge.

BRENDAN MAGUIRE: So essentially, a complete overhaul is what you're saying, right? As of today, what are the wait times for people looking for gender-affirming care in Nova Scotia? I'll leave that up to anyone who may want to handle that. How does that compare/contrast to the rest of the country?

I saw that Veronica had mentioned - and I think Riley mentioned - Montreal also in your opening remarks. Where are individuals going and what are they doing? I can just imagine what the wait time is and how painful it is to have to wait. I guess I'm looking for the wait times - have we seen it?

Then the Department of Health and Wellness maybe can touch on this - whether we've seen it go down or go up. What is the reality for those waiting, and what is the expectation from the Department of Health and Wellness for those waiting? I just want to get what's actually happening on the ground compared to what we're being told.

THE CHAIR: Mx. Nielson Baker, I see your hand up first.

RILEY NIELSON BAKER: I think in any conversation that we have about wait-lists, we recognize that it's hard to put a direct number on it because, are we talking about wait-lists for specific surgeries in general? In my time working on this in the last two years, I've met people who have waited over 11 years. I was very fortunate to meet a trans man - about a year ago today actually - who waited 11 years, and the only reason he finally got his top surgery was because he threatened to kill himself in his doctor's office. Eleven years for top surgery.

I think it's also important to recognize that while the requirement for a specialist letter in confirming aftercare is no longer a requirement, we are essentially sending every

single person in this province who wants gender-affirming care to Montreal. That change is basically meaningless. If everyone is still going outside of the province, then those changes are meaningless.

When we talk about what it's actually looking like for people who are waiting, I think it really depends. I've been waiting since November 2020, and I still haven't gotten my MSI approval because they've lost my application six times, and I'm sad to say that my story is on the lighter end of the typical experience. I've heard upwards of 15 times for MSI applications being lost or delayed.

That's what it is on the ground. I can't speak specifically to other provinces, but I know we have definitely one of the longer wait times in Canada.

BRENDAN MAGUIRE: Before we pass over to the Department of Health and Wellness, I'd like to do a quick follow-up. From my own experience, we had a gentleman working out of my office for the first two years that I was an MLA who was going through the process, and he actually left for Montreal and that's where he lives. We're still in close contact, and the big reason he left was exactly what you're saying and that was in 2013. What's the difference between here and Montreal?

RILEY NIELSON BAKER: The difference is that the surgeons are in Montreal. Since the doctor at the Halifax Sexual Health Centre - I forget his name - left a few months ago, we have no one who is providing this care in the province.

It is hopeful to hear that I know of at least five plastic surgeons who do general plastic surgery have stepped up to fill the gap, but they still have not received the training necessary in order to fill that gap. While it is very similar, what they do in general practice to providing gender-affirming care and gender-affirming surgeries, there is still a context change.

Realistically - and I like to always talk about how the recommendations that my organization are making are a stop-gap measure - we are asking for what the bare minimum should be. I will also recognize that as of the release of the WPATH Standards of Care 8, our policy is directly aligned - almost word-for-word - and we wrote this two years ago.

The standards are clear. The understanding is clear. Realistically, pie in the sky, like I say, beyond just the stop gap measures that my organization talks about, there is no reason for the Province of Nova Scotia not to be a hub for gender-affirming care in the Atlantic Provinces. There's no reason that we couldn't be publicly providing and working with the other Atlantic Provinces to be providing this care, so people don't have to go to Montreal, which itself is a private clinic, which itself increases health care costs on individuals and the state, as we are the ones paying for it. Whether that's a 10-year goal is another question, but there is realistically nothing stopping us from providing this care here except for a lack of prioritization of recruitments for doctors who can provide this care.

THE CHAIR: Would you like the Department of Health and Wellness to follow up?

[1:30 p.m.]

BRENDAN MAGUIRE: This is life and death, and this is, fuck - sorry. This is depressing and it's sad. My question is to the Department of Health and Wellness. You've heard this - I mean, is 11 years acceptable? It's probably not the norm. I hope it's not the norm. What are we doing to attract the proper resources here to assure this life-or-death process is happening?

TANYA PENNEY: I too hope 11 years is not the norm, and will follow up on that case. Riley, if you and I can have a conversation afterward, that would be awesome.

The other thing that I think I'd like to understand more about is your lost applications and see if there's some kind of conversation that I could have with that department to see if we can streamline that process.

I think part of the gender-affirming surgery referral process and just the kind of fillable PDFs and the things that we can actually do online now will actually prevent that paper-based system. I think even in the absence of me knowing about lost applications, just moving electronically, I think, will help with that. We'll touch base about that afterwards.

From a Nova Scotia and a Montreal perspective, I do know that Riley is absolutely correct. The majority of the surgeries that happen for gender-affirming surgery do happen in Montreal, and a small number actually happen in Nova Scotia, to the tune of 200 or 235. What we do in Nova Scotia is hysterectomies and oophorectomies, and then orchiectomies, penectomies, breast augmentation, breast reduction, and chest masculinization can happen in Montreal or Nova Scotia. In Montreal, it's typically bottom surgeries that happen.

When you get into that kind of center column of things that can happen between Nova Scotia or Montreal, oftentimes it's actually better patient care if we do send them to Montreal, especially if they're having bottom surgery as well. There's a continuity of care there. Because that specialization is in Montreal, it makes it more patient-centred to include two different types of surgeries. Even though they could have gotten it in Nova Scotia, they're better off having it in Montreal.

I hope that that answers your question.

BRENDAN MAGUIRE: Yes, it did, a bit. I'm just wondering: We're hearing the concerns on the ground today from these organizations. Obviously, there is a relationship between Montreal and Halifax, but the question is: What is the department doing to address these concerns that are very prominent right now?

TANYA PENNEY: Concerns in that . . .

BRENDAN MAGUIRE: Specifically, we heard from Veronica that all of these resources that are being supplied to individuals are on a volunteer basis. We know how long volunteerism happens. People get burned out. They get exhausted. Again, I will say that these are life-or-death situations, and we should not be solely depending on volunteers for these things. So I ask: What is the department doing to address the situation so that individuals like Riley and Veronica - and I imagine most people up here - are not spending countless hours of their free time doing what they love but also replacing work that should be supplied by the Department of Health and Wellness?

TANYA PENNEY: I think we just moved away from surgery - am I accurate in saying that - and kind of to more fulsome, culturally competent care? That's fantastic, and thank you very much for the question.

We, from a department perspective, fund a variety of community-based organizations, along with the Nova Scotia Health Authority, which manages the prideHealth organization, Sexual Health Nova Scotia, Halifax Sexual Health Centre - receives funding. We're in constant communication - or maybe not constant, but certainly quarterly conversation with them about what resources they need, what business proposals they have on the go, what it is that they can actually do in their own community.

As an example, Sexual Health Nova Scotia received an increased community funding grant last year so that they could actually start to meet that mandate and their strategic vision of getting into the community, into schools, to actually do some of that educational work.

THE CHAIR: Dr. Hickcox.

SAMUEL HICKCOX: If MLA Maguire would like, I can speak to one particular aspect of barriers to care and wait times, if you wish. This part of the barrier is probably at the core of a significant amount of the work that we've been doing to collaborate, and why it is that it wasn't just to any meeting with Veronica, and it's not just folks on Tanya's team but on my team as well who are really working to move the file forward and to bring about significant changes.

That is around the barrier to accessing psychosocial assessments. There are recommendations that are coming from Gender Affirming Care Nova Scotia regarding the number. We are certainly reviewing the entire policy and all the recommendations that Gender Affirming Care has presented to us. We take it very seriously and it's part of our ongoing work.

In addition, there are specific recommendations that are coming from the eighth version of the Standards of Care from WPATH as well, released in mid-September, under

review right now. There's a lot there, sweeping changes, as you had mentioned, and they're significant and important. Actually, I think there's a lot in there that, when adopted, will be for the better, for the good of the health of Nova Scotians.

Accessing WPATH assessors is something that is a significant challenge. It's not just a rural problem. It's certainly a problem in Halifax, but even more so, as some of our stakeholders have highlighted in other areas. Veronica can speak to what that experience is like in Cape Breton.

Our data shows that there are well over 100 individuals who are health care practitioners from a number of different professions who, according to MSI, have actually historically provided WPATH guided psychosocial assessments that have been accepted by MSI. We have a lot of practitioners, and yet for a number of those practitioners, it's difficult for people to identify them. It's difficult for people to access them.

One of the really important pieces of our general mandate work that we're doing at the Office of Addictions and Mental Health is to bring forward a system of universal mental health care that will help to lower the barriers to accessing care for community-based clinicians, including those who provide WPATH assessments. That's a significant piece that we're looking at.

One of the areas that we're really interested in is to see what the GRS clinic in Montreal - what their analysis of the latest version of the standards of care from WPATH is regarding the number of WPATH assessments that they require currently in order to access certain surgeries, particularly what are colloquially referred to as bottom surgeries. Right now, the current requirement for GRS is to have two separate WPATH assessments. For top surgery right now, it's one assessment.

We've reached out to them. We're trying to connect with them to really see what's the evidence base for that - what we can do to move the needle. We'll wait to see. For the time being, we're doing general work to improve access to universal mental health care, and in doing so, we expect to see an improvement in access to WPATH assessments.

THE CHAIR: MLA Maguire, you have about a minute and 45 seconds.

BRENDAN MAGUIRE: I'll pass it off to my colleague.

THE CHAIR: MLA DiCostanzo.

RAFAH DICOSTANZO: He gives me one minute. He was supposed to give me 10, but that's no problem. I'm grateful. My question was about mental health, so thank you, Dr. Samuel, for starting it. I wanted to mention as well that a study in the *Canadian Medical Association Journal* - and I'm sure you're very familiar with it - found that teenagers, youth, are five times more likely to have thoughts of suicide, and 7.6 times more

likely to have attempted suicide compared to the regular cis-gender population. That is huge. That is scary.

My question is: What are we doing for the youth in preventive - you said you have 100 practitioners - and putting them ahead of others, and giving them to the transgender who are looking for mental health. Because of suicide, they need more attention than any regular person who needs attention. How is the suicidal part being assessed?

THE CHAIR: Dr. Hickcox.

SAMUEL HICKCOX: In our work to fulfill the mandate of universal mental health care, what is absolutely essential is for us to hear from various communities with specific mental health needs, particularly those who face unjust, inequitable barriers to accessing mental health care in general. That would include individuals . . .

THE CHAIR: Order. The allotment of time for the Liberal Party has expired, so we have to stop questioning there. We'll move on to the NDP caucus. MLA Lachance, you can begin your questions.

LISA LACHANCE: Thank you so much for being here, for sharing your work, for sharing your passion and your stories.

I think I want to just start by pulling it all together because I feel like we covered a lot of ground in those first 20 minutes. I'll start by saying that one of my concerns, since being in this role and since advocating with the PC government around gender-affirming care, is actually the sort of incremental approach. The July 2022 announcement around letters: great, but it didn't get us to WPATH compliance. There's still a lot of gatekeeping, a lot of silos - to borrow some words from those who presented.

I guess I'm wondering if I could invite Mx. Neilson Baker and Ms. Merryfield to both comment on this question. What would it look like if we were actually WPATH compliant in Nova Scotia? What would be the difference? What would be the impact for folks?

THE CHAIR: Ms. Merryfield.

VERONICA MERRYFIELD: The impact of getting full WPATH compliance in place would mean a much faster progress for those who need it. The normal method is an individual would approach their doctor and ask for a referral. At the moment, that referral takes a long time. That's part of the answer to the question from Mr. Maguire. There are multiple stages involved and each of those takes time, and it's difficult to find anything outside of Halifax - whether it's Cape Breton or any other rural area - it takes a long time to get those.

It also doesn't help that a lot of those who do that work are looking to have multiple sessions, when really they should be able to make an assessment in one. All they're really looking for is whether there's any comorbid conditions that would be a causal kind of thing, rather than an effect. Multiple personality disorder is one that they might be looking for.

If they can do that in a single hit, they can then give the referral for hormones there under way, and within the period of time that is allotted by WPATH. If the paperwork were in place ahead of time for doing surgeries, then their surgeries would be done quickly too. Instead of facing multiple delays that are usually multiple months at best and are often a lot more - often 9 months, 12 months, 18 months that I've heard for referrals where they have to piecemeal from referral to referral - that would be one referral done quickly, get the paperwork, and get into surgery. Then they're through in the minimum amount of time that they need. That's the kind of difference that it would make.

RILEY NIELSON BAKER: There's been a lot of conversation around the physical systems that need to change, but it's important to recognize the actual outcomes of implementing WPATH Standards of Care Version 8.

To start, gender diverse, trans, and intersex rights are human rights. We have a responsibility as a province to ensure that we can all access free, accessible, and equitable health care - which is not something we can say about this province.

We also need to recognize that this goes beyond just the gender-affirming care surgery path because all of the conversations we typically have in this field surround specifically surgery and hormones. It doesn't even scratch the surface about whether or not I can go to the ER and a doctor will know how to treat me. That's the reality in this province: a trans person or an intersex person could go into an ER, and the doctor, or nurse practitioner, or other health care provider more often than not will not know how to treat them - and I mean both socially and medically.

The reality is that we're allowing people who cannot practise the full scope of medicine practise medicine in this province. It is unacceptable, and frankly, it's a violation of people's human rights, and we're providing different tiers of service to different people based on an immutable quality of their own.

We also need to recognize that a lot of what we're dealing with are social issues. In my conversations, and more and more studies are showing that a lot of the depression and mental illness that comes with being trans is coming from the society itself. While gender-affirming care helps - you can get all the surgery you want, but if your society is still hostile, that is just the reality.

Implementing WPATH 8 will help mainstream trans issues, trans health, and trans rights, and help bring these issues down in the holistic of the system. We know, and there is

provable evidence from multiple countries, that providing increased access to gender-affirming care increases economic security for members of our community, reduces rates of poverty and homelessness, reduces rates of unemployment, increases opportunities to access higher education, and decreases debt.

[1:45 p.m.]

While we're only talking about what the Province covers, what the Province doesn't cover is the larger portion of the list. That doesn't mean people aren't getting it. What they're doing is they're taking out debt. They're taking out loans and getting themselves into debt situations - basically, a medically-required debt trap that will, more often than not, ruin their lives.

We are more likely to be homeless. We make up the majority of the homeless population in multiple cities across Canada and across the world - especially in the youth homeless community. To distill it, studies have repeatedly shown that paying for these services is not only cost-effective, but has a positive economic trajectory for the Province as a whole. We will spend money now, and we will get money back in economic investment when these people are able to approach higher education, have jobs. They'll have chances to have a trajectory that's not negative - even neutral, but preferably positive. Those are people who contribute to the tax pool and more than cover the cost of their surgeries to the public health system.

I also think that there is another piece as well, and it goes back to the conversation that we had about volunteers. A lot of people don't know that GACNS is a fully, four-person volunteer team. I essentially work two full-time jobs, one fully unpaid. Without efforts like mine and like Veronica's, these changes don't get done. This is the reality across Nova Scotia and across Canada, where there is no funding for organizations like ours, which are realistically the only reason these issues are brought to light. I am very fortunate and privileged that I have enough economic stability that I can afford to take the time that I could be working a second job to work here and do this effort fully unpaid.

What I'm trying to get down to is that we also need to fundamentally address how we're actually engaging with the system of queer activism and queer rights and queer health in the form of permanent funding for a lot of these organizations. I don't know of a single one in Nova Scotia that has any form of permanent funding, whether that's federal or provincial. Very few do, and more often than not they don't.

The distillation is that this is such an all-encompassing issue that touches every aspect of Nova Scotian life. This scope is immense, but the potential could really change this province at the end of the day.

THE CHAIR: MLA Lachance.

LISA LACHANCE: I think both of your comments really touch on my concern with this incremental approach. This is the approach the minister has said more than once, but it really leaves people still fighting for their rights, for their dignity, and for their respect. In no other way do we expect anyone else to engage in the health care system in this way.

I think the cost is heavy. I think we have a dysfunctional system. I do think that the effect is that systemic impact then creates a societal impact around stigma, around discrimination, around exclusion. People who aren't involved in these discussions must think that there must be something wrong with those surgeries if it's so hard to get them - why are we fighting about them? They probably don't understand what this is all about.

I really think the incremental approach is not acceptable, and I think your call for funding for queer organizations is really important. I think we are a province that has no plan. The current government doesn't have a minister responsible for 2SLGBTQIA+ affairs. We don't have an action plan. The Liberals don't have a spokesperson. We saw a lot of the progress eroded under their time. I think it's kind of a mess, and I think that idea that there are 100 assessors but we don't know who they are, and people don't know them, is a good example.

I'm going to end that long statement with a question, a simple question perhaps. For Ms. Penney, does the Department of Health and Wellness plan to announce being WPATH 8 compliant, and if so, when?

TANYA PENNEY: The department is committed to reviewing the Version 8 that just came out on September 15th, so it is just two- or three-weeks in. We're committed to reviewing it. We're committed to moving forward in this gender-affirming care space using Riley's work and Veronica's work, and some stakeholder feedback that we've had from them along with prideHealth and other people around the province. We're committed to doing things differently and doing other things, but from a timeline perspective, I couldn't give you that right now.

LISA LACHANCE: That was going to be my question. It's disappointing to hear that there's no timeline for the review. Is there an expectation of when the review will be complete?

TANYA PENNEY: The review of the WPATH Version 8, or the entire consultation?

LISA LACHANCE: The whole thing.

TANYA PENNEY: These quick questions are hard to keep up with.

THE CHAIR: I'll figure it out. (Laughter)

TANYA PENNEY: I think Dr. Hickcox and my group is committed to reviewing the Version 8 assessment. If you wanted an absolute date that we would finish that review, I'm sorry, I wouldn't be able to give that to you today. I'm happy to have our teams work together over the next few days, and even few weeks, and kind of try to put some project timelines in place. If able to do that, we can hand those off to Minister Thompson.

LISA LACHANCE: I think that would be a great commitment. I know from my experience working in the Nova Scotia Government, you often have project charters, and nothing gets done if you don't have a project charter. This probably needs a project charter signed off at the deputy minister level and have some timelines attached to it, as well as resources, or it's not going to get done.

I do want to switch streams a little bit to talk more about health human resources and other resources in the public service. I know that there has been a review of prideHealth. First of all, I would say that we all know that they're a fantastic organization and probably didn't need a review - just needed some more money and some more capacity. I'm wondering if when that review is over there are planned announcements in capacity at prideHealth. As well, is there a plan to add DHW advisors on sexual orientation and gender identity and expression? These were in place some years ago. Those positions seem to have vanished under the Liberals. I know there's nobody doing that role right now in DHW. I'm wondering if there's a plan to replace that role.

TANYA PENNEY: I do just want to reverse a little bit because I've got the opportunity. We do have very committed people - team members - from both the Office of Addictions and Mental Health and the clinical portfolio working on this file. I don't want you to think that there weren't some dedicated resources attached to that.

PrideHealth did undergo a program review in January of 2022, and there was a bit of a deep dive from a stakeholder perspective. Currently, the next step is that the Nova Scotia Health Authority is working with the IWK Health Centre and envisioning what that expansion of services could look like - from a resourcing perspective, space, funding, and what have you. My office is looking forward to getting that proposal. We haven't gotten it yet. I don't know when to anticipate it either.

LISA LACHANCE: That would be great follow-up information in terms of what the deadline is for that review to be presented to you.

I understood that there was the withdrawal of services from one person who had been providing top surgery. At that time, the minister assured me that there was a medium-term plan, and the fact that folks were quite excited to step into that role. There were these five plastic surgeons. I guess I would ask, and it might be Ms. Penney who would have this answer: Have those plastic surgeons started providing services, including top surgery?

TANYA PENNEY: It is my understanding that they have, but I will confirm that by the end of the day.

LISA LACHANCE: Maybe to take it back to some of the community experiences - and again, maybe I'll start with Ms. Merryfield and moving to Mx. Nielson Baker. We talked a bit about the experiences in rural Nova Scotia, and I'm wondering what a better system might look like in terms of access. I think we are in a challenging health care situation. We have a health crisis in this province - I don't think we can say anything different. What elements could be included in a stronger system that would serve people across the province? Would that include some telehealth? What are the options?

VERONICA MERRYFIELD: The spread of the demographic in Nova Scotia is challenging for health care with half the population in Halifax and the rest spread around the province. All of the other areas in the province have this problem. It's not unique to Nova Scotia's health care either. It does exist in other provinces too.

As you mentioned, telehealth is a big one. If you've got a limited supply of practitioners through the province, the one thing that COVID-19 has taught us is that virtual access to medical professionals is something we need to use. But there needs to be a combination of what's locally accessible and what you need to use for virtual. If you're talking to a specialist - an endocrinologist, for instance - then you would have to be able to get your blood test done locally, and those test results being available to the clinician who you're going to see virtually.

There are some challenges with that, but it is something that I've put forward to these fine folks before as a way of using the limited resources that we do have for the betterment of everybody. That avoids one of the limits to access - and that's everybody having to come to Halifax. For some of us in the province, that's an 800-kilometre round trip. It is not a cheap endeavour.

RILEY NIELSON BAKER: We have to recognize that there's a premium on gender-affirming care for people who live in rural communities. We are requiring them to pay more than people who live in Halifax to access care, because they have to pay for gas or pay for a bus ticket to even see someone.

I do believe telehealth is part of the issue, but I think it goes even deeper into the availability of education to just general practice health care providers. It goes beyond just mental health and assessments - it goes into whether or not we can access a doctor, period. We talk about how the health care crisis and the doctor shortage and the wait-list here in Nova Scotia is so long. It is about two to three times longer for us.

I have heard so many stories of people who have had to make the decision of whether or not they stay with their actively transphobic doctor, or go on the health care wait-list for probably eight, nine, ten years until they see someone - and it's not like they

can just go to any clinic to fill that gap. The likelihood that the people practising in that clinic know how to practise medicine on trans bodies is closer to zero than anything else. There is such a huge gap that people are being forced to stay with health care practitioners who are actively transphobic and actively doing harm to them.

[2:00 p.m.]

It goes a little bit deeper still, because I have been contacted by so many health care practitioners over the last two years who are actively interested - more often than not, they want to know. They want to be able to help people in their community. They're just not provided the resources. More often than not, a lot of them said, well, I looked for help and education on this and I couldn't find it, or I called into the void and didn't get help.

A big part of that is that the primary provider of a lot of this within the health care system - as we mentioned, prideHealth currently has two staff members. One of them is working more than a full time job. They are incredible and I don't want to knock on the work that any of them are doing, because they are the reason that we are all still afloat here in Nova Scotia with queer health. But they're expected, these two people, and more than one FTE . . .

THE CHAIR: Order. The time for the NDP caucus questioning is over. We will move on to the PC caucus. I see MLA White has his hand up. MLA White.

JOHN WHITE: Again, I want to thank you folks for coming today and helping us sort through some of this information. After your opening statements, I particularly want to thank you, Veronica, and I'm very happy that I had the chance to shake your hand today. I'm happy you're here with us today. I hope that you find fulfillment in representing the people you're speaking for today. Keep speaking out.

Veronica, my question is for you actually. Have you seen any progress with this government on gender-affirming care? How has the relationship been in working with our government?

THE CHAIR: Ms. Merryfield.

VERONICA MERRYFIELD: I have seen progress, but I think it's because of I've been pushing. I was very pleased to be able to get the opportunity to speak to the team here, but I had to push on Minister Comer to get that to happen. I had been working with the previous administration to try to do the same thing. I just haven't found the right way into that.

Finding your way into the halls of power is not an easy thing as an individual, right? It takes a lot of work. There needs to be a lot more done, so whilst a start has been made,

it's a small start. It's almost a drop in the bucket, to be honest. We need a lot more a lot faster for all those people who are suffering - and we need it now.

JOHN WHITE: I appreciate your honesty. That's what I want to hear from you. Earlier, a couple of witnesses spoke about the lifting of the letter for gender-affirming care surgery. Can you share with us anything that you're hearing on the ground in the culture or people you represent? Can you tell us: Has it done anything? Has it had any impact? I realize there are some challenges with it as well.

VERONICA MERRYFIELD: It hasn't done enough. Because the reduction of that letter requirement is purely for things that are done in Nova Scotia and doesn't apply to Montreal, it means that people still have to do the second letter that Montreal requires. For the bulk of the people I'm advocating for, it's done almost nothing. I also know that it's the first of a set of measures that are going to be coming through. I will keep pushing until those measures get done.

I think Tanya alluded to this earlier. The work has to be done in negotiating with Montreal. Whilst Montreal is the preferred supplier at the moment, I think that we as a province also ought to open up the opportunities for patients to go anywhere in Canada, because there are other centres of excellence. Also, we need to open up the other surgeries that are available from Montreal and other places. At the moment, we have a limited number - 10 surgeries, I think it is. There are a lot more available. Those are a very limited number of surgeries for those who need them. We should be opening up.

As has been said earlier, this should be an investment in people. The reason I won over Brian Comer is I gave him the return on investment numbers in terms of what it would cost if you don't do this and what you would gain by doing it. The ROI is about 10 to 20 times. Invest in people.

JOHN WHITE: Before I pass it over to MLA Barkhouse, I just want to say that I'm happy to hear that you're going to continue pushing for that. That's what I want to hear from you.

THE CHAIR: MLA Barkhouse.

DANIELLE BARKHOUSE: Thank you all for being here. It's very informative so far. I heard from Ms. Merryfield and Mx. Nielson Baker what they felt about the subject, but I'd like to hear from the department. Where do you feel Nova Scotia stands in comparison to other jurisdictions regarding gender-affirming care?

THE CHAIR: MLA Barkhouse, would you like Ms. Penney or Dr. Hickcox?

DANIELLE BARKHOUSE: Sorry, Ms. Penney.

TANYA PENNEY: Sorry, I thought . . .

THE CHAIR: My mistake. Were you asking the department or were you asking . . .

DANIELLE BARKHOUSE: I was asking the department because I've already heard a little bit from Riley and Veronica, so I wanted to see what the department has to say.

TANYA PENNEY: I'm very sorry, can you repeat the question?

DANIELLE BARKHOUSE: Chewing up our time here. Where do you feel Nova Scotia stands in comparison to other jurisdictions regarding gender-affirming care?

TANYA PENNEY: I apologize. We are mostly lined up with other jurisdictions in Canada as far as the requirements, age, number of assessments, and that sort of thing. I think the one where it's obvious that we are not aligned with is the Yukon Territory.

DANIELLE BARKHOUSE: This has been touched on a little bit, but hasn't really been asked, so I'm just going to ask it, and this is going to go to Ms. Penney. Can you tell us a bit about the work being done to ensure timely access to gender-affirming care, and address wait times and delays that gender-non-conforming people experience when accessing gender-affirming care?

TANYA PENNEY: A bit of a bold question, so thank you for that. We know our transgender and gender-diverse Nova Scotians are experiencing challenges in finding appropriate and timely care, and we recognize that things certainly need to change. I think that I can speak on behalf of Dr. Hickcox, and maybe I will actually hand it over to him once I'm done. I think the changes from the gender-affirming surgery, although they may not sit in the Montreal space, certainly sit in the Nova Scotia space, creates a bit less bureaucratic red tape from the Nova Scotian surgery perspective.

We're also working with our academia partners to ensure that culturally competent care becomes part of university education. We're working with our rural health care providers on educational pieces - I know we've got some specific examples of what that education looks like. If you're okay, I might hand it over to Dr. Hickcox, and then maybe you can hand it back to me and we'll jointly answer the question.

SAMUEL HICKCOX: Thanks for the opportunity as well. I think the core message is that we recognize the importance of making changes. We recognize that people are suffering. It's not just we need to ensure equitable access to this absolutely essential, life-saving area of health care for individuals in the transgender, gender-diverse, and intersex communities.

One of the pieces to really emphasize is the degree to which the first point of contact for so many people with respect to health care is in the primary care space, and that we are committed to supporting education and the enhancement of capacity for primary care clinicians to be able to provide culturally safe, culturally appropriate care. That includes a more robust understanding of how to work with people who are non-binary, who have - as Riley had put it - an understanding of how to work with non-cisgendered bodies, and not just about the physical medical part, but about the complex biopsychosocial impacts that people are presenting with who are really just seeking help, compassion, and care.

I think that's an area that we're absolutely committed to addressing. We want to ensure that those who are in mental health crises - including those who are at risk of completing suicide - have an understanding of the kind of crisis supports that are available for them, generally speaking, through the mental health system.

If someone's trying to access that health care and they regard the health system as transphobic, as homophobic, as discriminatory, that's a significant problem. That's a barrier to access. People aren't going to trust that system, and that system isn't going to be able to effectively meet their needs.

Even in preparation for today's hearing, our office has reached in and is working with the mental health and addictions programs with the Nova Scotia Health Authority, and the IWK as well to understand some of the work that's been put in place to provide more formal education and anti-stigma work that's being done for the mental health and addictions system as a whole. I think that's an absolutely essential piece in order to keep people healthy and safe.

THE CHAIR: MLA Barkhouse. You have a little under 10 minutes.

DANIELLE BARKHOUSE: In fairness, because there are four of us and we all have a lot of questions, I'm going to pass this to Chris while I think some more.

THE CHAIR: MLA Palmer.

CHRIS PALMER: I too want to thank you all for coming today. Every opportunity I have to come and sit in this House and in this committee, I don't take it for granted the ability to learn so much. Thank you for the information today. Today is no different. I'm learning a lot today as well.

I'd like to shift gears just briefly for one minute, and talk about family and family support. I'm sure that some seeking this care are not as fortunate to have a supportive family as others. As I look up in the gallery, I'm sure we have family here today, here to learn and to be part of this process. We welcome you here, everyone in the gallery today.

I guess my question is in regard to family supports for youth, adults, parents, other family members. I'll maybe ask Dr. Hickcox and anyone who would like to answer. Could you share with us what types of resources are available to parents of gender-nonconforming youth who want to provide informed information and support to their children or other family members?

THE CHAIR: I'll start with Dr. Hickcox.

SAMUEL HICKCOX: Sure. I'm going to keep it fairly brief in general. I think there's a lot more work that needs to be done, but certainly organizations like prideHealth have been able to deliver education, as well as facilitate support groups for parents who are interested and willing to learn and grow, and go on this journey with their loved ones who are identifying as transgender or gender-diverse or are actually found to be intersex.

We'll be very curious to see what the IWK and NSHA bring forward in terms of the needs that can be met through prideHealth and what can be done to support organizations like prideHealth.

THE CHAIR: MLA Palmer, you kind of mentioned - anybody else?

Mx. Nielson Baker.

RILEY NIELSON BAKER: I think the important conversation that we need to have around parents is that all parents are coming from a place of wanting the best for their child. They are coming from wanting to make sure that the child has the best chance of success and happiness in life. They're going online, and because there are no publicly provided resources that are accessible - not just here, but everywhere - they're getting the wrong answers and they're punishing their kids for it, intentionally or not. That's why I always like to have these conversations, recognizing that it comes from a place of love and a place of fear.

Regardless, children still have a right to access the health care that they need to survive and that is going to make them happier and keep them alive, to put it bluntly. I want to highlight some of the work that the Canadian Mental Health Association of Nova Scotia is doing. They are currently working on creating six education sessions directed at parents so that we can ensure, in this province, that there is a source of accurate, non-biased information available to parents in the form of lectures and other information sessions and options to help address these issues. But it's important, regardless of all the work that we do, recognizing the rights of children to access this care as well, and to be able to explore who they are in a safe environment.

I know that there are people outside today who are handing out papers that are just perpetuating lies about the importance of hormone blockers. They give children the chance to not experience the irreversible changes of puberty and irreversible changes of hormone

replacement therapy and just have a chance to determine who they are. To deny them that right because of a toxic parent who is coming from a place of fear and love - we have to recognize that reality also when we're talking about families and family support, because they're not going to get the family support regardless.

[2:15 p.m.]

That's something we talk about a lot in this community - that most of it is found family. I'm very lucky to not have to rely only on my found family, but for the majority of us, that's not the reality. They're going to have harm caused to them, and we must do everything we can to lessen that harm as much as possible.

THE CHAIR: MLA Palmer, you have about three and a half minutes.

CHRIS PALMER: I'm going to go back to something you had mentioned, Dr. Hickcox. You had mentioned a little bit about universal mental health care, as we move forward developing that. Could you maybe just reiterate and expand a little bit on the role that universal mental health care access plays in improving supports for people from gender-diverse communities in improving the care we're talking about today?

SAMUEL HICKCOX: We all know that we're essentially facing a significant set of challenges regarding health human resources. This has been mentioned a few times today. That's not up for debate, is it? The current health workforce is exhausted as well, so there are challenges there. Universal mental health care as a mandate item has as one of its core goals to bring mental health clinicians across the province who are often working in private spaces back into the system, such that individuals will be able to access the care that those clinicians provide, regardless of any inequities. That's the core piece of work.

It's not enough to say that we're going to render a host of clinicians available. We have to make sure that those clinicians are connected to an overall health system. We have to make sure that we are identifying the needs that these clinicians can meet, and that mental health clinicians overall can meet. There's no way that we could possibly do that without understanding the needs coming from stakeholders, particularly stakeholders of those who are part of equity-deserving groups. That includes individuals from the 2SLGBTQIA+ communities - specifically here it includes those who are transgender, gender-diverse, and intersex.

We're really excited about the future because it hopefully involves a lot more conversations and a lot more pushing, not just from the individuals you see here, but the people from the communities at large, so that the care that's being provided is one that's culturally competent, appropriate, and doesn't retraumatize or marginalize individuals, but actually sends a very clear message that the health system cares, that it's for these individuals, and that they will get the help they need. I think that's absolutely essential for the mental health and well-being of anyone who is trans and/or gender-diverse.

As it has been mentioned by Riley previously, the mental health impacts of . . .

THE CHAIR: Order. The allotted time for the PC caucus questioning has expired. We will now move on. We have eight minutes per caucus. I see MLA DiCostanzo with her hand up, so you can begin.

RAFAH DICOSTANZO: Maybe I can start with letting Riley continue to talk about the organization that is not here. There's only one that is funded, and that is prideHealth. I'm surprised that they're not here as presenters today. Maybe you can let us know why, and also, if you can continue your conversation. Then I have one quick question for Dr. Hickcox as well regarding mental health.

RILEY NIELSON BAKER: It's because Gary doesn't have any physical time left on their hands (Laughter). They physically can't be everywhere at once, and like I said, they work more than a full-time job as educator, navigator, policy analyst, advocacy within the system, advocacy without the system. They serve the role of what should be five, or six, or seven positions.

We have to reflect on when prideHealth was originally created. It was originally only designed to serve Central Zone, and it is still to this day designed to only serve Central Zone, even though its mandate is the entire province. Until recently, they only had one, but now they have two, because I believe they have a nurse practitioner who has since been hired to help Gary out slightly.

We can't expect one person to be the voice of not just the trans community, but the queer community in its entirety. This goes beyond just trans people, intersex people and gender-diverse people. The entire queer community - between 10 and 20 per cent of Nova Scotians. We have purposely created a system that is designed not to work. We haven't funded it, and we've left it the same forever. Gary can't do everything. As wonderful as he is, he cannot do everything.

We also have to reflect on the fact that prideHealth lacks the standing of other health equity groups within the province. There are advisors on Black and African Nova Scotia health care, advisors on Indigenous health care, advisors on disability health care, but there is no advisor on queer health care. He does not hold the same power and position as other health equity groups in this province, and it's important to reflect on that.

It's also important to reflect on the other major advocate in providing resources like this in this province, and that's the Halifax Sexual Health Centre. Practically every single member of our community I have spoken to has touched Halifax Sexual Health Centre at some point in their transition. But even though they are the primary provider of queer health care in this province, they're funded as a boutique health clinic. They receive, I believe, 73 cents on the dollar of every other health care provider in the province, and that is a legislative choice. That is something that is enshrined in legislation.

We have created a system in which the two major providers that are provincially funded for queer health care, queer education, navigation, for policy advocacy are either fully understaffed and not designed to help anyone outside of Halifax, or are being paid 73 cents on the dollar for equivalent services. We need to call it what it is: That is systemic discrimination.

RAFAH DICOSTANZO: Thank you, Riley. You're really so passionate and so well-spoken. I really thank you for your advocacy. I also wanted to ask Dr. Hickcox - we started with the mental health, but for example, you mentioned there were 100 new practitioners that we're adding to our mental health. Just before I forget that this current government has committed to universal mental health, when is that going to happen? It hasn't happened, correct? Do we have a deadline? When do we expect that to happen? That's Question 1. Let's finish that, then I'll come back if I have time for the other one about the education of doctors at the MD level.

SAMUEL HICKCOX: I want it to happen yesterday, like you. I think everybody here would want that. We want to do it right in terms of universal mental health care. I think that today is a great example of why it's absolutely essential that the people who are at the centre of defining health care are Nova Scotians, and in this case, folks like Veronica and Riley - and not just them, as Riley has pointed out. We want to do it right. We don't want to just have one conversation, two conversations, and then say, "Oh, we can tick that off the list."

We're involved in very significant, robust engagement with health care practitioners, different sectors, and most importantly, with Nova Scotians who are living with certain health conditions who are facing barriers to equitable access to mental health and addiction care. That's our work right now. We're really focused on that. We'll let you know when we're done with that part, and we'll go for it. It's going to take some time. We all know that. I certainly would invite you as well to stay in touch with our office as we continue to progress as quickly as we can. I promise.

RAFAH DICOSTANZO: Yes, the mental health part of it as well. What we need, and parents would need, is educated doctors in this field. How much education are new doctors who are graduating - what is the number of hours that they're getting in regard to this, and many other things that are evolving and changing and they need to know? What is the education level, and what is the government doing about that - or your department?

SAMUEL HICKCOX: I'll just speak very specifically about the work of the Office of Addictions and Mental Health, and then I would look forward to also passing it on to my colleague Tanya to continue this. One of our core principles, one of the ways that we work at the office is to identify what all of the factors are that we can see that are really impacting the risk of developing mental health and addictive disorders - those challenges, which include the social determinants. It includes the impact of stigma and of a lack of education

of clinicians within the health system to provide the care that we know the evidence says they should be providing.

We are working across a number of government departments, across sectors, and with our partners in community to identify and address these issues. Specifically, we do work to support our colleagues in building a more robust system of professional education throughout all educational and other entities to ensure that professional training is such that clinicians are left armed with a more appropriate set of clinical skills. A very general answer . . .

THE CHAIR: Order. The Liberal caucus questioning time has expired. We'll move on to the NDP caucus. I see MLA Leblanc has her hand up. You can begin.

SUSAN LEBLANC: Thank you all for being here. I just wanted to ask about the media report last month of the incident involving a transphobic health care worker in Truro. It was a number of people involved, I guess. It was a conversation that really underscored for people who heard about this and witnessed it the need for increased education for all health care workers. That's not just in the training institutions, but as people move forward through their careers.

Advocates have called for an increase in education. I'm wondering if this is something that the department is undertaking. If so, can Ms. Penney provide an update on a timeline, and also if the training will be mandatory for health care workers?

TANYA PENNEY: I'm aware of the tweet from somebody in that area of the province, and I think I'll just speak more generally just to be respectful of that incident. The Department of Health and Wellness expects our colleagues within the Nova Scotia Health Authority and the IWK to treat people with respect. Discrimination, racism, homophobia, transphobia in any form isn't acceptable and won't be tolerated. That was the conversation that we had with the Nova Scotia Health Authority at the time.

SUSAN LEBLANC: That's good to know. What a relief. Mx. Nielson Baker has talked about the need for practitioners who understand how to practice medicine on trans bodies. Will there be any specific training undertaken for folks who are already working in the medical system - awareness training, competence training for people who are already working in the system?

TANYA PENNEY: It is my understanding that Nova Scotia Health Authority in particular has ongoing competency requirements from an employment perspective. I can certainly get you some details on that as a follow-up. I don't know if Dr. Hickcox has something that he can recall off the top of his head, and I don't want to put you on the spot. I'm happy to get the answer later.

[2:30 p.m.]

SAMUEL HICKCOX: Again, I can only speak really to the component of training that's directed towards clinicians, staff, physicians who are working in the Mental Health and Addictions Program for the IWK and NSHA. I do know that beyond prideHealth, the Nova Scotia Health Authority has a provincial training program called PCTEL. They're focusing on a number of specific clinical domains and competencies that all clinicians - not just entry-level clinicians - are getting exposed to over time in an iterative way. It's not just a volunteer organization that's providing training, but it's actually making statements about specific competencies that are required, such as trauma-informed care, for example, and understanding harm reduction.

That would include specific educational interventions that are designed to allow those mental health clinicians to provide care in a way that's not transphobic, not homophobic. There's an understanding of what individuals' human rights are, and also significantly, what the specific needs are - how to work with folks in a way that's less alienating and marginalizing and more welcoming, inclusive, appropriate, and safe.

THE CHAIR: MLA Leblanc, you've got four minutes.

SUSAN LEBLANC: A number of folks have mentioned organizations like the Halifax Sexual Health Centre, Sexual Health Nova Scotia, and prideHealth. We've heard from some of those organizations here at this committee, and we know that those organizations are chronically underfunded. When we hear folks like Ms. Penney from the department talking about how important those organizations are, and folks from the community talking about how important they are, I want to ask a very specific question. Given that we know that those organizations are chronically underfunded, will we see substantial and meaningful increases to their budgets in the upcoming budget in March, or whenever it is?

TANYA PENNEY: I think you might recall back on May 11th an appearance that I made here, along with Mx. Heide, who at the time was the executive director of Sexual Health Nova Scotia. She has since stepped down and Stella Samuels is the new executive director in that space. Following that meeting, we had some very definitive conversations around referrals, navigation, sexual health, reproductive issues, some of the things that sexual health centres were needing to do in their communities. We were able to give them some substantive funding. Sixty thousand dollars is what they asked for, and that's what we gave them from a permanent funding model moving forward.

From a community-based organizational perspective, the primary care team within the clinical portfolio is really looking at community-based organizations, including Sexual Health Nova Scotia, but how it is that we can support them moving forward in a sustainable way. I think if you recall our conversation in May, the difficulty was they always have to

come after grants or come after annual - they have to fill this form and fill that form. So we've taken some significant steps certainly with Sexual Health Nova Scotia since May.

SUSAN LEBLANC: That's great to hear. I hope it keeps going. Yes, operational money is obviously much more effective than project grant money, even if it's the same amount.

Quickly then, I wanted to ask Mx. Nielson Baker about your comment on the boutique funding. Can you just quickly expand on that? What would it take, given that the Halifax Sexual Health Centre offers and has a demand in offering real primary care to folks in Halifax and beyond? Given that, especially, there are going to be primary assessments done for gender-affirming care - and those assessments need to be longer than your average primary care medical appointment, one would assume - what is needed at that clinic in particular to better serve the needs of people seeking gender-affirming care?

THE CHAIR: Mx. Nielson Baker, you've got about a minute.

RILEY NIELSON BAKER: I can speak really quickly if I need to.

It is important to recognize that the Halifax Sexual Health Centre, due to constraints on its funding and its staffing, is no longer doing primary assessments of members of the community who need gender-affirming care referrals, because they are so overstaffed and underfunded. They receive, I believe, about 75 cents or 73 cents on the dollar for each of the procedures that they do provide.

It's important to recognize that they are not just serving the trans community or the queer community, which they absolutely are, and are one of the only institutions that can provide gender-affirming recommendations, even though they're not - sexual health, HIV support, monkeypox support - supports that you can't really find anywhere else. They can't meet demand. They just physically can't anymore.

I lost my train of thought. I apologize. ADHD is fun.

THE CHAIR: Order. The time for the NDP caucus questioning has expired. We will now move on to the PC caucus. I see MLA White looking at me. MLA White.

JOHN WHITE: Before I start, Riley, would you like to finish your sentence?

THE CHAIR: Mx. Nielson Baker.

RILEY NIELSON BAKER: The end of my sentence is "I have ADHD and I forgot what I was about to say." (Laughter)

JOHN WHITE: Riley, I'm sitting right here next to you. Now I'm lost.

Listen, we talked today about the stigma that's around the 2SLGBTQI+ community, and I believe Dr. Hickcox mentioned earlier the need for some training with health care professionals. I want to come back, because that never came back to Veronica and Riley. I wanted to hear if you can share with the committee the importance of positive culturally responsive interactions.

By the way, I'm a counsellor myself, so I understand what that means. But I want to hear from you guys what that means in your relationship with looking for health care. I want to hear from you how we can achieve that.

RILEY NIELSON BAKER: I want to start with this: I worked in the field of sexualized violence and domestic violence for over a year in programming and provision, so I understand the importance of providing contextually inclusive services. Without these services, no one can access the basic human dignity that they require under this current system. It goes from, yes, a greater societal issue, but we have to start addressing that somewhere. We can't start addressing that without inclusion of the health care system - and honestly, led by the health care system.

If we can't enter, like I mentioned earlier, an emergency room after a major car accident and the doctor looks at us and says, "I don't know what to do here. I don't know what their drug interactions are going to be. I don't know the impact of testosterone or estrogen or puberty blockers or other hormone blockers," then they're not able to practise medicine.

It was a question that was mentioned earlier as well. Under current medical schooling education requirements, there is no mandate to even learn about queer issues, trans issues, trans health care. If we're lucky, it's tacked on at the end for diverse communities at the end of a class. That's terrifying, that we are a two-sentence, two-week max, shoved in there with a bunch of other marginalized groups. What does that say, if that's the kind of health care education we're providing, that we're an afterthought? It's tacked on if we're lucky.

There is some great work going on in Newfoundland and Labrador. I had the privilege of meeting one of the people who is leading. They're amending their health care provision to make it not only so that these courses are not just two weeks, maybe a sentence in a syllabus, but are either required courses that are whole semester courses or preferably - as medical education experts say - these issues need to be embedded in individual course materials.

If you're talking about issues of endocrinology, then why aren't trans examples being circled in there for general health care discussions? We're talking about surgical provisions. Why isn't the health example that they're using a trans person? It goes so fundamentally in whether or not we're even mentioned in health care courses, let alone in continuing education once people get out. I think part of the issue too is we're all trying to

rely on up-and-coming health care practitioners who are not getting the education they need to address this issue when two-thirds of the people who will also still be practicing medicine are the people who are already licensed in this province.

It's not enough to ensure that medical schools are teaching our existence and how to interact with us and not kill us. We have such a huge presence of people, medical practitioners in this province, who unless they are mandated are never going to even give us a second thought. It's so fundamentally systemic that it goes down to whether you even hear the word "trans" in your health care class. Maybe you hear it once or twice in your entire medical school career. How do we expect people to take us seriously from a culturally competent perspective if they can't even hear their professors say the word "trans"?

THE CHAIR: Ms. Merryfield.

VERONICA MERRYFIELD: I wanted to briefly follow up. We were talking earlier about medical clinicians in training. We didn't talk anything about the other professionals who work in medical environments. Front desk workers, for instance, need that training too. The bulk of the complaints I end up dealing with are not always from the clinicians. They can be clerical staff.

The second thing about education - I've lost count of how many doctors I've ended up educating about trans issues because they don't have that when they come out of training.

THE CHAIR: MLA White.

JOHN WHITE: I was writing down some of the stuff you were saying. I'll go back to Ms. Penney now. Can you tell us what is being done to make health care services inclusive to those accessing gender-affirming care to help them feel safe?

THE CHAIR: Ms. Penney.

TANYA PENNEY: I think we've actually spoken about a fair amount of it today. It's really around education and cultural competence, just to follow up on Riley's point around education in the academic world. It is about that from a starting-of-a-career perspective, but it's also that cultural competence that MLA Leblanc was asking me about earlier. How do we actually make sure that people who are practicing today get that ongoing cultural competence?

Once all of that happens, we do need to put some public policy and some protocols and procedures in place for gender-affirming people seeking care in the health care system, so that they actually feel respected and safe and welcome, to Dr. Hickcox's point earlier. Every Nova Scotian should feel safe walking through any door of a facility. Any

practitioner's office, the Halifax Sexual Health Centre, any facility that's delivering health care should be a respected, safe and welcoming place for people.

[2:45 p.m.]

THE CHAIR: MLA White, you have 40 seconds.

JOHN WHITE: I do have a question I want to ask. I will come back, because all my lines of questioning here were tied together. I want to come back to Dr. Hickcox again, because I want to know how the branches of the Department of Health and Wellness communicate and how they collaborate now, because this is obviously systemic. That's where the problem is. I'm asking Dr. Hickcox. Will you help us understand how you collaborate on that through departments?

THE CHAIR: Dr. Hickcox.

SAMUEL HICKCOX: Ten seconds. Within one to two months of both Tanya and I coming on board with the Department of Health and Wellness, we were meeting with Veronica, and it was a true honour and pleasure . . .

THE CHAIR: Order. (Laughter) The PC caucus's time for questioning has expired. We do have a short opportunity for some closing remarks if any witnesses would care to give some closing remarks.

RILEY NIELSON BAKER: I am here representing 52 organizations across Canada and internationally that have endorsed the work that Gender Affirming Care Nova Scotia has done. That includes organizations like the Nova Scotia Nurses' Union, the Nova Scotia College of Social Workers, and Doctors Nova Scotia. These are some of the most influential organizations in the health care practice here in Nova Scotia, and all three of them have endorsed what we have proposed long before WPATH 8 came out.

I also want to emphasize that this is a failure of all Parties, and I mean that in the most literal sense. This system was brought in under an NDP government and was designed to fail. The Liberal Party had eight years to address it and failed, and we are now seeing continued failure. The changes that have been made are not enough, and we cannot celebrate, and we cannot expect our community to celebrate until all of these changes are made. A lot of human rights responses are framed in allyship. I have a very good friend of mine always likes to say: Who gave you the title of ally? Ally is not a title, ally is a verb, and if you aren't doing anything to be an ally, then don't call yourself an ally.

We're talking about an issue of human rights, and - I know some people are concerned - economic issues. Whatever angle you would like to take - human rights? Great, let's take human rights. There's no human rights reason not to do this. Economic? There is no economic reason not to do this. As Veronica and I have both mentioned, the

amount of money we're going to spend on trans health care and gender-affirming surgeries has an ROI of - what, 20 you said? Twenty times? There's no economic reason not to do this. It will change people's lives.

We need to be able to guarantee that all health care practitioners in this province are able to practice medicine. There's been discussion of the incident in Truro with Liz. I've had the great opportunity to talk to Liz on multiple occasions since then and we have to reflect upon not just what happened, but the context in which it happened.

Hysterectomies are the most common gender-affirming care surgery that are received by individuals who are assigned female at birth. We can't even guarantee that one of the surgical institutions that trans people are most likely to have contact with are not just going to not cause them harm, but you know, actively disrespect them. For all they know, there was a trans person listening, and Liz is just the one who called them out because more often than not, trans people just stay silent because we deal with every single action.

I always tell people, it's all well and good that you are affirming, but 90 per cent of my social interactions are not, and that is part of it. We just sit there quietly and take that 90 per cent because it is mentally and physically impossible to address all of it.

We talk about incremental change. If 10 years of waiting isn't incremental, then I don't know what the definition of incremental is. We have lost the right for incremental change when it took more than a decade to get anything, especially when people have been saying that this system doesn't work since the day it was introduced. We have been crying since Day 1.

I moved back to Nova Scotia three and a half years ago. In this time, I have done a lot more work than much of government has on the trans community in God knows how many years. We did this work for free. We did it for government knowing that if you don't come to government with specific proposals, you cannot guarantee that something is going to change - and we're a lot cheaper than contracting out to Davis Pier Consulting. We did it for free. Don't need to call Davis Pier. We did it.

When we politicize trans lives, trans people are the only ones who lose, and when they lose, they die. We have to recognize all of our faults in this. We're all at fault. I'm at fault, everyone in this room has some level of fault in the reality that we're currently living with. We have to decide whether we're finally ready for action that is actual allyship.

I'm really hoping going forward that we can work with this government on these issues. I'm hoping that actually occurs, because we've only been contacted once, and that was six months ago. We would love to work on these issues, but no one seems to want to work with us on them.

THE CHAIR: Does any other witness have closing remarks? Dr. Hickcox.

SAMUEL HICKCOX: It's our hope that at the end, Veronica, you want to end with some, which seems apt to me.

We made some initial steps in July. I think those steps were just the very, very beginning of what we hoped for with respect to collaboration within our departments, which was sort of speaking to what was being asked about before. More importantly, building a program of care that's actually with the people with lived experience at the centre of that is where that collaboration really belongs.

We're just getting started, and we know that more needs to be done, and we can't do it without the community. I can't imagine another community for which this would be more apt - equally apt, perhaps, but nothing about us without us would be of the ethos that we want to remember and, if you will, the slogan that we want to remember and a guiding principle of how we're going to be generating policy at the Department of Health and Wellness, including the Office of Addictions and Mental Health.

I completely agree that allyship, trust and hope are not words. These are earned, and we have work to do to earn those titles, and for people to feel hopeful.

I think that it's humbling to conceptualize the amount of resilience that's required for these individuals - and for those up in the gallery and for others - to just get through day-by-day, not to mention articulate the impact that a transphobic society has had on those individuals. It demands a tremendous amount of resilience. In that sense, I think these individuals - by working with their found families and with their communities - are finding the resilience and working on their mental health. But ultimately, this isn't resilience they should have to be tasked to find. That's what I will end with.

THE CHAIR: Thank you, Dr. Hickcox. Ms. Merryfield.

VERONICA MERRYFIELD: I wanted to end this session with just going through some of the people I currently support and where those things are. I'm going to de-name everybody, but this is just the people I'm working with in Nova Scotia, so this is a small set.

There's I. His mom is the breadwinner in that family. He's going to be aging out of having his Lupron being paid for by health services. That's $400 a month that she's looking to try to find, and she barely gets over minimum wage.

L., who is struggling to find a job and keep a roof over her head. Currently housing, just about paying it, but she can't afford to eat, as well, and she can barely afford to pay for her hormones, or she has to go and move home into a basement with a very transphobic father. M. and her son, both trans. Two working parents, minimum wage. They can barely afford the costs of hormones. It took them months to save up to do the name change.

S., who is struggling with the costs of housing but has decided to do the hormones because that's more important to her. J., who can't work for a number of reasons, lives in a travel trailer on the $430 that the government provides for her to live on. She has to choose between working illegally or starving, and she still needs her hormones.

J., who after a lot of turmoil, has ended up going to the Yukon. I worked pretty hard to advocate for her to get her four months of hormones so that she could move to the Yukon and not have the difficulty of that three-month overlap of health coverage before it becomes available when she gets to the Yukon.

P., who is in school, wants her identity protected when she's moving between schools and is looking to get blockers in the struggles that her parents are having. D. who ended up moving to Saskatchewan of all places because he had parents over there or family. X., who's coming as a foreign student from the States to CBU and is struggling to navigate the system for things like name change, hormones, access to health care. S., who's gone off to university, wants to get surgery. She's eligible for surgery now. She transitioned quite some years ago in school. She can't get the timing arranged between her courses and when it's available.

K., who needs a second surgery because the first one didn't work out so well. She had to go on her own. She has considerable PTSD, and she needs help getting her there, because nobody else is going to take her. J., who is looking to go for surgery too. She's in her twenties and is going to have to do it alone, but over my dead body. I'll go with her. J., who is in a long fight at home with religious parents. He is struggling to do what he needs to do. He wants to leave home, but he's too young.

A., whose doctor is not referring, despite being given all the details that doctor needs for doing referrals. A. wants a new doctor but realizes that if he leaves the doctor he has, he's not going to get the service he needs. K., who can't get her doctor to agree to do breast augmentation despite there being a legal precedent for doing it. M., who's ex-military and has PTSD is trans, and the amount of support that she needs is not available in the system. I spent quite a lot of time talking to her. M., who is fully engaged by the government but is still having to wait and wait for getting her health care.

I could go on. There are a lot more who I deal with, but those are the ones from Cape Breton and Nova Scotia. Thank you for this opportunity.

THE CHAIR: Thank you to our witnesses. We have two minutes left in our meeting, but this ends our committee meeting for questioning. I would like to thank the witnesses on behalf of the committee for this very informative, very important discussion. Thank you to everybody in the gallery for attending and being patient with us. I hope it was insightful for all of you as well. You're now available to leave.

Committee, we have a couple of items I want to get done quickly - whatever we can get through, but we'll start with the committee business. (Interruption) No, but I'm going to go through this committee business. We have a minute and a half. MLA Maguire.

BRENDAN MAGUIRE: We'd like to put a motion on the floor . . .

THE CHAIR: MLA Maguire, I'm going to go through committee business, and if there's time at the end for a motion, you can do it then. If not, we'll put it into the record. You can send it in, and we can discuss it next week. I don't have a problem with a motion.

BRENDAN MAGUIRE: The motions usually come after the witnesses because it pertains to the witnesses.

THE CHAIR: I recognize that, but we have a minute and I'm going to finish what we have here. Is there approval? (Interruption) I'm going to finish off with this. (Interruption) Is there agreement? (Interruption) MLA Maguire, I'm going to move on to committee business. We can discuss this after.

We have the approval of the annual report. This was sent to members on September 22nd and again this morning. Is there any discussion on . . .

SUSAN LEBLANC: I move that we approve it.

THE CHAIR: We have a motion to approve the annual report. Basically, the motion would read that the committee approve the annual report as submitted and table it in the next sitting of the House of Assembly.

All those in favour? Contrary minded? Thank you.

The motion is carried.

Time for the meeting has expired.

[The committee adjourned at 3:00 p.m.]