PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON THURSDAY 18 AUGUST 2022.

Ms TAMARA REYNISH WAS CALLED, MADE THE STATUTORY DECLARATION AND APPEARED VIA WEBEX.

The Committee met at 10.32 a.m.

CHAIR (Ms Forrest) - Welcome Tamara. I am Ruth Forrest, the chair of the committee. We have Mike Gaffney and Sarah Lovell here. One of our members, Nick Duigan, is not available today. We thank you for coming before the committee and apologise for the interruption to our proceedings a couple of weeks ago when the Government prorogued parliament. Anyway, here we are and thank you for making yourself available today.

The evidence you are about to give is covered by parliamentary privilege, it is sworn evidence, and we will get you to make the statutory declaration that you would have there. It will be recorded on *Hansard* and form part of our evidence and the transcript will be published on our website when it is available later.

Do you have any questions before you wish to start about that process at all?

Ms REYNISH - No, thank you.

CHAIR - Tamara, if you could make the statutory declaration and then we invite you to introduce yourself, make some opening comments, and then members will have questions for you.

Ms REYNISH - Excellent. Okay, is there a specific statutory declaration?

CHAIR - Sorry, I thought you might have had a copy. I will read it to you and ask you if you agree, just give me one moment.

Do you, Tamara Reynish, solemnly and sincerely declare that the evidence you are about to give the committee is the truth, the whole truth, and nothing but the truth?

Ms REYNISH - I do indeed, to the best of my knowledge.

CHAIR - Thank you. Over to you.

Ms REYNISH - Thank you. I am Tamara Reynish, I am Canadian by birth. I have been living in Tasmania for seven years now and I am a doctoral candidate at the University of Tasmania here in Launceston, where I am also a mental health professional and was recently a co-signatory and a researcher on a Department of Communities Tasmania government grant, looking into the mental health of east-coast LGBTIQA+ Tasmanians.

Thank you so much to Jenny Mannering for her organisational support, and to the honourable Ruth Forrest, and to the committee as well for the interest in my written and verbal presentation.

Access to mental health care, as you know, is a fundamental human right as outlined by the United Nations in 1948, and yet, access to mental health care is not a reality for many rural and remote Tasmanians. Access to mental health care is even less of a possibility for many rural and remote Tasmanians who are sex workers, kink-oriented, or are lesbian, gay, bisexual, transgender, intersex, queer, asexual, or any other of the identities included under the LGBTIQA+ acronym.

My expertise drives from my doctoral research which explored the mental health and related service use of LGBTIQA+ people, kink-oriented people, and sex workers exclusively in rural and remote Tasmania, so people residing in Hobart or surrounding areas were excluded from this research. This research is the first of its kind in the state.

These three populations were explored in combination due to their shared experiences of discrimination, stigma and their compromised access to the human right of bodily autonomy. The locale for your inquiry and my research is important because morality is associated with increased homophobia, transphobia, isolation, identity concealment, and limited community belonging, as well as limited access to services, all of which have been proven to negatively impact mental health.

My PhD research showed that generally my participants have poor mental health, very high psychological distress, and low resilience. What is worse; their access to mental health care and the care they received was generally reported to be poor. Almost 100 per cent of my participants who accessed health care ran into barriers of some kind or another which impeded their access to care, their ability to get quality care, and again, harmed their mental health.

There were common barriers in these rural and remote communities. There were simply no mental health services, or where services did exist, most of those were not tailored to serve people who are LGBTIQA+ or they were too expensive. Another issue was that they were run by faith-based organisations. Many participants reported that they avoid faith-based organisations due to their history of persecuting people who are different or have alternative ways of being and doing. Another barrier was too few staff and long waitlists.

My results also show that psychologists, psychiatrists, counsellors and social workers in rural and remote Tasmania are, for the most part, culturally incompetent, so that is to say they are untrained and biased against people with alternative sexualities and genders or people who work in the sex industry.

Some mental health professionals were even openly insulting, openly discriminatory, and even refused to provide care to my participants. These barriers are not only unethical, unprofessional, and violate the state's own anti-discrimination legislation, but they bred help-seeking avoidance and prevented people from looking for care and they also, again, worsened mental health.

To put my findings into context, let us consider some national research into LGBTIQA+ people. I am specifically speaking about Private Lives and Writing Themselves In by Hill et al, which you have heard about from the other parties presenting and making submissions to this inquiry. Those national studies do not give a representative picture of mental health of LGBTIQA+ people in rural and remote Tasmania. That is, as I demonstrated in my written submission, and will restate here, my research shows much higher levels of psychological

distress, depression, anxiety, and suicidality in rural and remote LGBTIQA+ Tasmanians than in their national counterparts.

LGBTIQA+ people, sex workers, and kink-oriented Tasmanians in rural and remote Tasmania have a pronounced need for dedicated mental health care due to much discrimination, stigma or lack of access. This inquiry could make all the difference. You have the opportunity to erase health and geographical disparities and provide rural and remote populations, access to quality mental health care.

I listed several recommendations in the written submission that I ask you to consider with utmost openness. Essentially, I recommend that (1), the Tasmanian Government works with local education facilities and local branches of health professionals' governing bodies to ensure that all subsequent graduating classes of health professionals who work here are trained to work with diverse populations while honouring the state's anti-discrimination legislation.

Recommendation (2) is that you fund a tailored dedicated mental health service that is headquartered in rural or remote Tasmania and staffed by rural or remote Tasmanians. LGBTIQA+ people, sex workers, and kink-oriented Tasmanians in rural or remote areas need dedicated and trained mental health professionals in their local government areas. They need rurally based, face-to-face support and services that are tailored to their needs that are not merely an offshoot of southern services.

I understand, there will be now questions.

CHAIR - Sure, thank you. If I can start, Tamara, I appreciate the submission and your verbal evidence. You said this is the first or only research that has been done specifically on rural Tasmanians,

Ms REYNISH - Yes.

CHAIR - In your submission, I think you referred to it in your verbal evidence there about the national percentages of people who fall under the LGBTIQA+ group in relation to psychological distress, depression, anxiety, suicidality. So, the national figure, does that just relate to Australians living in rural or remote areas, so we are comparing rural people with rural people?

Ms REYNISH - No, that was all people included in those studies.

CHAIR - Okay, so do you have similar figures relating just to people living in rural and remote locations in Australia and in your research in Tasmania?

Ms REYNISH - I do not have the exact figures on hand exactly, but the rural and remote reportings in those national studies are comparably as low as the ones included in my written submission.

CHAIR - Okay, so if we were to say that the levels of psychological distress for all participants in the studies, nationally 57.2 per cent of people in the LGBTIQA+ have high to very-high levels of psychological distress and in Tasmania it is 66.2 per cent, that disparity would be the same in rural Australia as it would be in rural Tasmania? Is that what you are saying? I just want to clarify that we are being accurate with the figures, that is all.

Ms REYNISH - Yes. No, I am actually holding up the Hill report now. I do not have the exact figures, but I can inquire into them for you in those documents. They have included nearly 158 people in their national study, over more than 6000 people,

Ms LOVELL - Just to clarify, chair, is your question whether those percentages and those figures are higher for rural or remote Tasmanians compared to rural or remote Australians?

CHAIR - Yes.

Ms REYNISH - In a short answer, definitely, yes. Regardless of where rural people are located, whether it be Canada, Australia, Mexico, people who are LGBTIQA+, let alone people who are rural, have worse mental health than their urban counterparts.

Ms LOVELL - Is it worse, Tamara, in Tasmania than it is for the same demographic, same location, same group of people on mainland Australia?

Ms REYNISH - Yes.

Mr GAFFNEY - Thanks Tamara, you mentioned there about a good model where you had health professionals who had all been trained. Instead of doing the big acronym, we are going to call them 'rainbow communities', if that is alright, because it is quicker. So, trained in that rainbow professional development so that they can be in rural and regional Tasmania. We have issues here in Tasmania as we do not have enough professionals anyway. It has been presented to us that perhaps a good way of operating would be to have a specialised professional clinic or something in Hobart that would then operate a hub and spoke model where they can send out professionals to remote areas in Tasmania for two or three days to be that resource. I suppose the conundrum is that the best model would be to have resources around Tasmania, but is that a practical model knowing the limitations we have on experienced people in Tasmania? I hope my question is not too confusing. I got confused.

Ms REYNISH - I think you're asking what I'm proposing. If your inquiry is into rural and remote Tasmanians, one simple question is, why would you then base any new initiative in the south? If you're actually concerned about the mental health of rural and remote Tasmanians, why, based on your statement, would you only serve them two or three days a week?

Mr GAFFNEY - What would you suggest would be the optimal - are you suggesting there be professionals throughout Tasmania and throughout the health service in all those rural and remote areas?

Ms REYNISH - Yes. As I indicated in the written report, the idea is that every single mental health professional in the entire state is competent in working with any diverse population. That's the ultimate goal and quite frankly, according to their codes of ethics and their professional conduct, shouldn't everybody who works in the field of mental health and physical health be competent in working with populations that are from cultural and linguistically diverse backgrounds or people who have experienced sexual assault or any of the populations that are marginalised, including LGBTIQA+? That ultimately should be the goal of health care service in the state, in my humble opinion.

I think an inquiry into rural and remote Tasmanian's mental health that then institutes any solutions that are based in urban areas kind of defeats the entire purpose of the inquiry into rural and remote mental health and physical health. My suggestion would be to put it somewhere in rural and remote Tasmania and then have the spokes, as you spoke of, which I believe you're quoting Working it Out's presentation, have the spokes go outwards from rural and remote Tasmania to the rest of the state, including only serving the south for two or three days a month.

Mr GAFFNEY - Thank you.

CHAIR - Tamara, you mentioned an increase in educational awareness in all our health professionals. I agree, everyone who works in the field would benefit from having experience and some level of expertise in a whole range of diversity factors because we are a multicultural and diverse community. You mentioned, with regard to that, similar curricular advancements made in Canada, for example. Could you describe the actual curriculum changes that have occurred there and where they've occurred?

Ms REYNISH - Yes, exactly. There were several reports. I can send you the links to them and I believe I did cite the references in the written publications. If you wanted to Google it, it's generally referred to as something called 'queering the curriculum'. What happens is the curriculum is developed based on a range of gender identities, we don't just look at the binary. This is especially important in physical health, for example. Curriculum is just made inclusive language-wise, approach-wise. It's not assumed that someone's gender is known just by simply looking at them. If they present with long hair and we assume that they're female, no. That's not happening (indistinct). They've been done in Montreal, in Quebec, in Newfoundland. There's a range of them. They've been done in several places throughout the world but especially in nursing. Nursing is taking quite a lot of advances in queering the curriculum and making it more curriculum for all physical and mental health providers.

CHAIR - That's interesting. Recently, I was reading the College of Midwives Australia - not their journal, the newsletter. It's a publication they put out and they had a whole volume basically on this topic, of non-gender specific language and stuff like that, where it's appropriate. Yes.

Ms REYNISH - It's a very easy change. Michael said something about using 'rainbow communities' because it's shorter and easier. Not to pick on you, Michael, but why couldn't we just take the time and say LGBTIQA+? Rainbow communities is considered inclusive by some but it's not representative of the range and breadth of all the identities within. So, it is just a matter for not making white, cisgender, heterosexual people the norm, not assuming we are the norm, because as you have said, we are indeed a diverse and multicultural and multifaceted community here in Tasmania.

CHAIR - Another point you made in one of your recommendations was:

> Launch rural and remote anti-stigma initiatives: Create and launch locally designed, locally based, ongoing anti-stigma initiatives to reduce stigma against mental health and normalise help seeking.

Is that related to the LGBTIQA+ community? I am just asking you to unpack that and what you think it looks like.

Ms REYNISH - Yes. Broadly, to be truthful, so far as anti-stigma initiatives, my research found that there were 60-odd operating, most of which. in the country, only three were based in Tasmania and only one of them was ongoing; the other two were during short term mental health weeks, and it is for all populations. Stigma against having mental health issues and seeking support for any mental health issues is off the charts regardless of who we are talking about. It is really high in LGBTIQA+ populations as well.

So, anti-stigma or normalising mental health and making it a topic of regular conversation. For example, we do risk assessments and safety assessments, and so far as OH&S is concerned -

(FAULTY SOUND THROUGH WEBEX)

CHAIR - We just lost you a little bit there, if you could go back a little bit and restate what you just said?

Ms REYNISH - Generally, I was saying that all anti-stigma initiatives should be for all the population, but including for LGBTIQA+ populations because some people have historically been blamed and hidden and made fun of, and it is not normalised for having mental health issues or discussing them, let alone seeking help for them.

I encourage you to consider ways in which there might be some initiatives, and again, not reinventing the wheel. Are there are other initiatives elsewhere that could be implemented here? Based here in rural and remote and not just as a mental health week - a great initiative, but it is a one-off, it is one week. What about the other 51 weeks in a year?

CHAIR - You made the point that morality increases the reality of homophobic attitudes and challenges to people accessing services broadly. Can you talk a bit more broadly about that? The negative impact, particularly on mental health, but I assume it affects other areas of health too.

Ms REYNISH - Yes, definitely. There are definitely heaps of trauma researchers like Bessel van der Kolk who indicate that when you experience mental health trauma, your body actually registers it and it stays in your body. There has been a lot of correlation between physical health issues resulting from mental health issues and vice versa. The body/mind connection, I am sure you are familiar with it.

Definitely, accessing mental health support or physical health support in rural and remote areas is really difficult and when there is one mental health professional in a community and they are homophobic, then what is a person to do?

In Tasmania, you are now working on a Tasmanian bilateral agreement which I find interesting, because you are actually promoting phone services and I am assuming, perhaps wrongly, that you have not actually looked into LGBTIQA+ people's usage of telephone services for mental health support. My research says that telephone usage for mental health support by LGBTIQA+ rural and remote Tasmanians is very low.

So, one of the very approaches to providing mental health support in remote areas is the phone lines, but usage is actually really low because they cannot be guaranteed that they're going to get a culturally competent ally or informed person when they ring up. A person who's LGBTIQA+ has to out themselves if they want to talk about their relationship, and that can be really confronting to a person's mental health. Initiatives that work for cis, hetero people, cisgender people who accept the sex they've been assigned at birth, or heterosexual people, don't always work for LGBTIQA+ people.

Rural initiatives, urban initiatives are proven - even by your own - the Commonwealth of Australia did a report in 2018 and they fully acknowledged urban initiatives do not work in rural areas. The Head to Health, another bilateral - another aspect of your Tasmanian bilateral agreement, Head to Health had stride. It's interesting how much money is actually being spent on building renovations, from building here on Canning Street and it's not actually being given to people who require mental health support. Investiture in mental health has to be in mental health. It shouldn't be in infrastructure.

CHAIR - If there was a dedicated telephone service for LGBTIQA+ people with mental health challenges, would that be appropriate? That could be staffed from anywhere, obviously. One would expect you would get a sensitive and understanding ear at the other end.

Ms REYNISH - To be clear, there is one national one: one. A couple of them have a text, you can text in if you have any issues. Yes, that certainly could be an issue if people were guaranteed to be - the staff who worked it were inclusive, allied and culturally competent. That could be one solution but people generally overwhelmingly prefer face-to-face support.

Ms LOVELL - Tamara, one of the parts of your submission that we haven't really touched on much yet is around sex workers in rural and remote Tasmania. I'm just wondering if you wanted to expand on that at all?

Ms REYNISH - Yes. Sex work is somewhat legal in the state. It's still legislated but it has been decriminalised in Victoria and in other parts of the country. People who have to conceal their identity, conceal their jobs, conceal or hide who they are, that has been proven over and over again to harm and hurt people's mental health. You know the proverbial, 'Hi, how are you? What's your name?' 'Tamara.' 'What do you do for a living?' I can't answer that if I'm a sex worker, and I automatically have to start my relationship with you as hiding and concealing and being uncomfortable.

A vast majority of people who are transgender, for example, dabble in sex work so that they can afford to pay for any changes or alterations that they wish to make to themselves, their dress and their body, medical or otherwise. Also, young people in this terrible housing market - people engage in sex work to pay rent. If we're not normalising that and we're not acknowledging that it's a large part of people's lives, then I think we're really remiss because sex work isn't hidden and it shouldn't be hidden. That's another thing that I think people would benefit from, instead of concealing it but making it more open, because the more we have to hide, the more it hurts our psychological makeup.

Ms LOVELL - Do you know, Tamara, if there's any - you've referenced a report here, Daniel (2010). Do you know if there's any data or research specifically around sex workers in rural and regional Tasmania?

Ms REYNISH - No, mine's the first.

Ms LOVELL - Okay. Thank you.

Ms REYNISH - Scarlet Alliance had - the former leader - I can't remember her name, Lisa something, I'm sorry, I can't remember her surname, did some documentation but it wasn't in rural and remote based, it was Hobart based.

Ms LOVELL - Thank you.

CHAIR - Tamara, I don't have any other particular questions. Is there anything you'd like to add before we wrap up?

Ms REYNISH - I do have a closing statement.

CHAIR - That would be great.

Ms REYNISH - Thank you. As I said, much research, including that conducted by the Commonwealth of Australia shows that urban-based approaches to mental health care don't work in rural and remote areas. By establishing mental health services in rural and remote Tasmania, you could dilute the urbancentricity of mental health care approaches and aid in the development of establishing vital, localised, specialised rural and remote approaches to care. What's more, your inquiry could address the erasure of rural and remote Tasmanians from mental health curricula, policy and services and in doing so, your inquiry could right egregious disparities and wrongs.

Thank you for your time.

CHAIR - Thanks very much, Tamara. We've covered a lot of the various areas within our terms of reference that have been really helpful for us. Thank you.

Ms REYNISH - Thank you. If you have any further questions pertaining to my submission or additional statistics or documents, please don't hesitate to have Jenny or yourself contact me. I'm very happy to help out with this. Thank you.

CHAIR - Thanks for your time.

WITNESS WITHDREW

Committee adjourned at 11.01 a.m.