THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A SUBCOMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON MONDAY 21 JUNE 2022.

Dr LYNN JARVIS, CEO, WORKING IT OUT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

The Committee met at 10.52 a.m.

CHAIR (Ms Forrest) - Welcome Lynn, to our hearing for the Rural Health Inquiry and thank you also for the submission. As I said to Rodney Croome when he appeared before us, we apologise for the oversight in not including the LGBTIQ+ community in our defined terms of reference, but we do thank you for the submission and the extensive data provided and reports that have been done to date on this important area.

We invite you in a minute to take the statutory declaration and introduce yourself and speak to your submission then the committee will have questions for you.

It is a public hearing. You are covered by parliamentary privilege while you appear before the committee. If you have any questions feel free to ask. If there is anything of a confidential nature you wish to discuss with the committee, you can make that request and we will consider.

We may have our other member Sarah Lovell join, she was unavailable this early this morning, but she may be able to Zoom later. She will just appear on the screen if she does.

If you would like to introduce yourself and speak the submission please.

Dr JARVIS - My name is Dr Lynn Jarvis. I am the CEO of Working It Out, Tasmania's primary LGBTIQ+ support advocacy and education service. Working It Out has been in existence since the late 1980s and came into fruition as a result of the divisive debate around the decriminalisation of homosexuality in this state. It was in fact led by concerned community members from the north-west coast who commissioned a report into the impact of that debate and the increased number of suicides amongst young gay men in the north-west region, in particular.

That report was called Working It Out and recommended the establishment of a service to support the health and wellbeing needs of LGBTIQ+ Tasmanians. We have been doing that since that time. We are still a small organisation in many ways, although we do a lot with a little.

Our primary focus has remained on the preventive health side, providing support to individuals on sexuality, gender identity and intersex status. That includes support for individuals, families, friends, partners, loved ones through one-on-one direct support and also, small groups - peer groups that we run a lot. We also do a lot of education and training. We also use our core funding to apply for grants to provide services in other areas. Two main areas we do that work in at the moment are in aged care, where our national Silver Rainbow partner program is to try and increase the inclusiveness of aged care facilities for LGBTIQ+ people, because that is a significant issue.

The other major area we work in is schools. We deliver the Value in Diversity framework in the school system and were lucky enough to get a bit of extra funding last year from the premier's Child and Youth Wellbeing strategy. We now have two people working in that area to do the whole state, K-12. That is a big increase for us.

I have some statistics here. Rodney and Ruby gave you some statistics and I am sure you will get a few more from, I believe, Tamara Reynish, she is also putting in a submission. There is a plethora of evidence talking about the increased health and wellbeing needs of LGBTIQ+ people, particularly LGBTIQ+ Tasmanians and then once again, every level you get those needs increased, people in rural remote communities.

This evidence is robust. It has been around for a long time and it shows there are significant mental health concerns in the community, but also other health concerns. We have high rates of cancer, smoking, alcohol and drug-related issues and high rates of service avoidance also. A lot of these can be put down to the ongoing discrimination and exclusion that LGBTIQ+ people face. People often say to me, 'Well, hasn't it got better?' And my answer, 'Yes, of course, it's got better,' and that's great, but the bar that we started on was so low, that better has still not got us that far.

One of the things I have reflected on lately a lot is the pandemic, and the pandemic before that which, of course, was the AIDS pandemic, which today has killed 36 million people. If we look at the response to the AIDS epidemic, even though it was many years ago and the response to this current pandemic, you can see the way that LGBTIQ+ people's lives continue to be both moralised and politicised and that has not only a big impact on health outcomes, but it probably plays into why these poor outcomes remain significantly unaddressed.

In Tasmania, for example, we have no specific services other than Working It Out, which as I said, is a preventive service to support the health needs of LGBTIQ+ Tasmanians. Even Working It Out struggles to provide services in rural and remote communities, or regional communities. Workers in the north and north-west each have 13.5 hours a week to do that work and it means that we constantly struggle to get staff. Staff find it very difficult to do the role in that time and so they leave or they need to get more work, they leave and then we have a service gap. We find somebody else and start again.

We do the best that we can. We do make sure we have services in the north and north-west. We provide services by phone, internet and by mail. We have used all sorts of creative ways, even before the pandemic, to try to support people but we feel we are always under providing the kind of services people need.

It is a population group that has particular issues with safety and trust are really important issues for LGBTIQ+ community members. They need to access services that are both safe and trustworthy and knowledgeable about the health needs of the communities. That remains an ongoing struggle.

CHAIR - Thank you. Lynn, one of the comments you made was regarding service avoidance. Can you talk to us more about that and the implications that has? Is it because services are not readily available and is a barrier to access, or is it more that it is a personal choice? I'm just trying to break that down and what you actually mean.

Dr JARVIS - Yes. It is a combination of things. There is a big lack of suitable services, then people mainly need to access mainstream services. What any LGBTIQ+ person looks for and I don't care how out you are, how confident you are, myself included, what you are always trying to find is a space that is going to be accepting of you as you are; that is going to provide appropriate services.

For many of us, we do find those services and that is great, but many people have negative experiences or they hear of negative experiences or have had negative experiences in the past. Sadly, we all know that negative experiences have way more weight than positive experiences.

CHAIR - Three times as much at least.

Dr JARVIS - Yes. The LGBTIQ+ community in Tasmania is relatively closely knit and bad news travels fast. Service avoidance often comes down to people choosing not to have service because they are not sure if the service they are going to access is going to be acceptable and accepting. And beyond accepting, I guess, we want affirming services. We don't just want to be tolerated and accepted. We want to be celebrated in all our wholeness. People are looking for affirming services, where people's sexuality or gender aren't questioned and also that people will provide adequate service.

I'd like to give you an example. It's a couple of years old now - but not very old - of an older transgender woman who had breast implants. She went to her surgeon and the breast implants were leaking, so the surgeon said to her, 'We need to take those out and I'll put in some new ones.' She said, 'Fab, that's great.' Unfortunately that surgeon then left and a new surgeon came along who she went to see. That surgeon's response was, 'Yes of course we'll take them out, but we're not putting in new ones. That's not a good use of taxpayer money'. The response to that particular situation is that that woman then decided not to have the breast implants removed at all, because for her wellbeing, having breasts was more important than addressing the issue of the leaking breast implants.

I don't hear thousands of stories like that, but I definitely do hear stories like that and that's in Hobart. I don't like to make -

CHAIR - Is that recent?

Dr JARVIS - Yes, in the last two years. I also had - again this is hard - it's a bit hot in here - a Hobart story, so I know this is a rural health inquiry but I guess a story that I had a couple of - this is very recent. I don't know if anyone was at the parliamentary reception we had a couple of - that very day a medical student came into my office and was really distressed because she had heard mental health clinicians, senior clinicians, joking about trans people in the staffroom and she identified as non-binary. She felt very uncomfortable about that situation.

I think we can't make judgments about where - that's one of the things, we don't know where good service is going to be. I don't know where good service is. People ring us all the time and say, 'Can you recommend a psychologist,' or, 'Can you recommend a surgeon, or a doctor,' and we have a handful of names on our list which often change as well. Then we go, 'Sorry, we don't, it's too hard'. Service avoidance often comes down to stories of bad experiences - they travel fast - but also not knowing where to access appropriate care.

It is the same in aged care, we find that a lot. People will not access aged care services, particularly in the home, because they are afraid of people coming into their home who will not be affirming or accepting of who they are.

Mr DUIGAN - I was going to ask if there was any work being done in formalising those lists, or trying to?

Dr JARVIS - Well I had a side of the desk project that I was working on with a few volunteers, but my desk just got, it's fallen from the side of the desk into the bin, literally, metaphorically I guess because I just haven't had any chance to do that. We were going to try to do a survey and get a list of health professionals across the board: mental health, GPs, speech therapists, all kinds of people. But that's just a project that we haven't been able to progress. We didn't have the resources to do that, so it is very hard to keep those lists up-to-date because people change. Also at the moment it's hearsay to a large extent, which can be difficult, because you might go to someone and have a great experience, and you might go to the next person and have a bad experience. It is kind of hard.

CHAIR - On that, is it fair to say that this is almost person-dependent, in terms of whether the response is - as the surgeon. We know that in our rural communities, particularly with GPs, that there is a high reliance on locums, and locums come and go regularly. So is this compounded in rural areas?

Dr JARVIS - Definitely, it can also be compounded by the use of overseas trained doctors. Again, I'm not making any aspersions on those particular health clinicians but some communities that people come from are not as accepting of LGBTIQ+ folk, or people can feel uncertain about whether they'll be accepting. So, I think that definitely plays into that.

The other thing about rural communities as well is that issue of trust. For anybody - LGBTIQ+ or not - that relationship of trust between their GP is important.

We imagine all folk now are out, loud and happy, but that is not the case. A lot of people in rural communities still live closeted lives, closeted maybe to their family, in particular. So accessing health care locally can be really problematic.

Similarly, and I made the point in my submission, it was a point that came in and was highlighted during COVID-19. We imagine that online is great but some people do not have that space in their house where they can have a private online conversation with somebody else. They might not have access to the data, or the technology to do that. Sometimes these things that seem like simple fixes don't actually work in our space.

Mr GAFFNEY - Two questions there. What role does the university have for the LGBTIQ+ community with their student doctors or the doctors coming through? What input does your organisation have so that the new doctors coming through are well versed, or at least experienced in how that should be managed?

Dr JARVIS - Well, the extent of my understanding is that I do a yearly lecture to first year students about an hour and 10 minutes. And that is basically LGBTIQ+ one-on-one.

Mr GAFFNEY - That is it?

Dr JARVIS - As far as I know, that is it. I do not think there is any specific content beyond that. They may include - it would be good practice if they included diverse humanity in their case studies and patient-doctor interactions, but I am not sure to what extend that happens. I know there are some people in the university medical school who want it to happen, but it is a busy place.

Mr GAFFNEY - Are you aware of any programs and modules in other universities with doctors and staff where they do have a module, or whatever they do for - ?

Dr JARVIS - No, I keep a listing of courses, online and face-to-face course options for health practitioners outside the university sectors, which I share around where I can. But, I am not aware of anything, which does not mean it does not happen. It just means I am not aware of it.

Mr GAFFNEY - Okay. We heard through other evidence that was given to us that during the COVID-19 time, a lot of Tasmanians actually made contact with Melbourne service centres, for lots of reasons, and they were inundated with Tasmanians wanting assistance. With that in mind, what would be the model that you would see best suits the Tasmanian LGBTIQ+ community for health needs?

Dr JARVIS - I think it is a two-pronged approach. I am a keen advocate for dedicated LGBTIQ+ services because that immediately solves 99 per cent of those trust and reliability issues. You could pretty much guarantee clinicians in that space, who had the skills and knowledge to provide appropriate care. So, that is one strategy.

The second strategy is we always have to work on making mainstream services inclusive, because not everybody will or wants to use a dedicated service, or could use a dedicated service. It is impossible to have that service available everywhere. So, we still need to make sure that that happens, but I cannot see that happening quickly, to be honest. So, eventually, a dedicated service will be redundant, if everywhere was affirming, accepting and knowledgeable of the health needs of LGBTIQ+people. Then we could perhaps do away with any dedicated service. But, as I said, I think there is a fair way off.

Mr GAFFNEY - Have you had discussions with the THS or officials there about the concerns of your community and what needs to happen?

Dr JARVIS -Sure. We have ongoing discussions with the Department of Health and others. I am a member of the Department of Health's LGBTIQ+ reference group and I certainly try to bring the research to their attention. I think that they are all aware of that now and they are certainly making efforts to do better. I am not sure if you are aware of the Department of Health's new e-learning module, which is fantastic and has been created with the input of LGBTIQ+ Tasmanians so it's a really positive step and we're hoping that will become a standard training module for all Department of Health staff. That will be a great start.

We also work with the Primary Health Network and Primary Health Tasmania. It's a capacity issue as well. Working It Out is the pseudo peak. We're expected to do all this kind of stuff and I do as much I can, but of late it almost becomes the more you advocate for inclusivity, the more people want to do better, the more they come to us and ask for support and advice and staff and we go - 'Aghh'. It's very hard to do that at the moment. I was looking the other day and I am on 11 government committees and there are about six inquiries and

submission processes - quite serious ones: sexual violence; children in institutional care; family violence; drug and alcohol; the whole Tasmanian health system. There are all these sorts of inquiries going on and we're invited to make submissions but the capacity to do so is really limited, so that's an issue that plays into that. It really relies on Working It Out and in my capacity as the CEO I've got 101 other things to do as well - I have 18 direct reports now. It relies on - if we're not in that room, and occasionally people like Rodney can do that as a volunteer, but if we're not there then nobody there represents our communities so that's another broader capacity issue in this space.

I've even forgotten your question, Mike.

Mr GAFFNEY - No, that was fine; thank you. Thanks, Ruth.

CHAIR - It was more about the solutions.

Dr JARVIS - Probably, my first ask would be for a mental health service because I think that's the biggest area of health need and perhaps there are some private moves afoot to start looking at that GP physical health-land which might eventuate in that space, which will be fantastic.

Mr GAFFNEY - You mentioned that there has been improvement with the Tasmanian Health Service acknowledging and recognising, and now it's just finding solutions to try to address the issues. Is that fair and reasonable?

Dr JARVIS - Yes, I think it's a long-term problem. We're not going to get that change happening overnight, so it's ongoing commitment. In the end, it comes down to resourcing. There has to be some commitment towards resourcing.

I think you probably also know that the Tasmanian Government did its survey last year, Telling Us The Story, and that has a number of recommendations in it, including the need for a funded mental health and suicide prevention strategy and also under that a dedicated LGBTIQ+ mental health service, but that's something that does need to be supported. It's hard to do that without any government resourcing. I think people know the problem and people want to do something about it but it's that level of commitment to actually doing something - that's the next hurdle that we've got to get over.

Mr GAFFNEY - Thank you. Thanks, Chair.

CHAIR - Part of me thinks surely it all comes down to respect and it all comes down to accepting people for whoever they are - whether they're from a different culture, whether they're from a different sexual orientation, different gender-diverse approach.

Dr JARVIS - Can I just challenge that for a second?

CHAIR - Yes, up here it says that but that's not the lived reality.

Dr JARVIS - No.

CHAIR - And that's the challenge here so in terms of helping people to be more aware, and the training program for the THS you've spoken about, and I'm not suggesting this is easy

for a moment, but for the people like the trans woman who had the leaking breast implants or even the medical student who had that unfortunate experience in the tea room, do they ever go through a formal complaints process, and particularly to the Health Complaints Commissioner because that's where they can make recommendations as well? What are the barriers to actually achieving change through those established mechanisms that I would be recommending to other people who have complaints around the health system?

Dr JARVIS - That's really interesting. If you talk to Sarah Bolt from Equal Opportunity Tasmania (EOT) she would say we don't get many complaints from this area.

I was talking to a transgender woman this morning attending a course somewhere and she said that her teacher knew her from another time and constantly misgendered her. I asked, have you made a complaint?

'Oh, no. I don't want to cause trouble.'

Well, I said, it doesn't have to be trouble. Maybe, there's something you can do.

'But you know it might affect my course.'

I think people often underestimate the emotional labour a complaint of any kind requires and often LGBTIQ+ people have extreme levels of emotional labour already to deal with, particularly if you are transgender or gender diverse. That is a lot to be managing on a day-to-day basis and I can totally understand why people don't go through with complaints because that means there is a whole lot of other stuff you are going to have to deal with and you don't even know the outcome. Even if it is a good outcome it is going to take time, energy, emotional labour if you like. It is a difficult one.

We are recommending to the Department of Health that one thing we would like to see is a one-stop-shop complaints process for all government services. It could be hosted by DPAC and if you are LGBTIQ+ complain here or give good feedback here. It doesn't have to always be complaints, but we have to name it up as something like that. And then somebody would have responsibility that may say this the Department of Health, this is Police, this is Department of Justice, this is Communities Tas, whoever it is. It would be a great place to keep that. I still think we wouldn't get that many complaints because people just don't want to complain.

CHAIR - I accept that answer and I thought they would be the real barriers. It is a barrier for people who aren't part of the community too in many respects but there are a whole heap of other overlays there. If there was this 'no wrong door, one stop shop' type of approach you talked about where the person who had the grievance could have almost have a person walk with them through that process, do you think it would make it easier and then potentially affect change? Because it is change that you want but you don't want the people to have to be almost retraumatised by the issue that has led them to the complaint.

Dr JARVIS - It could do but we often get people who come to us because they have had a bad experience, so they will talk to us about it and we will encourage them even to put in an anonymous complaint through EOT and offer to help them. The number of times that people say 'oh no, I don't want to'. There is also a certain level of conditioning in the LGBTIQ+ community that this is what you have to expect around these kinds of experiences, that you

don't have the right to complain, that you don't have the right to have the same services as other people.

We have to remember that even though marriage equality was 2018 or 2017, a lot of people have lived much more less inclusive lives that we have now and so a lot of people still carry all that with them and a certain degree of internalised homophobia. I remember my friend who is in the Salvation Army once saying to me, 'I was brought up to hate gay people and then I was one.'

CHAIR - So you have to hate yourself then, don't you?

Dr JARVIS - Yes, exactly. You are brought up to hate yourself. I think some of that lingers. It is one of those wicked problems, really hard to solve.

CHAIR - If there was no financial limit say, what do you think is the most important thing that if you were the minister you could put in place, or the premier? Because it should be a whole-of-government approach, to make the biggest difference in ensuring that LGBTIQ+ people could access the services they need. We are focusing on health here, particularly rural health. Obviously, it is broad, but what would be one of the most impactful things you could recommend for people of your community to access non-discriminatory, inclusive services in health care in our communities, particularly our rural communities?

Dr JARVIS - That is a big question, I am not sure that I can give an answer that is 'one thing.' I am going to skirt around it slightly. A lot of the issues come down to ongoing either experiences of discrimination or inappropriate care, say in the health system, or fear thereof, which sits behind community attitudes. That is a hard one. In the short term, perhaps an LGBTIQ+ specific health service would be a good thing, but to me that is not the complete answer because you really want every health service to be inclusive and knowledgeable. I guess that is a bigger problem. Sorry, I have not been able to give you that one thing.

CHAIR - This highlights the challenge though.

Dr JARVIS - One thing I would like to say though, from looking from that perspective. I have lived most of my life in Launceston and a recent import back to Hobart. It pains me that we cannot offer some proper services as an organisation in the north and north-west. There was a bit of money put aside in the last budget which was for LGBTIQ+ peer health navigators which the Department of Health is talking to Working it Out about and I am hopeful that might be able to lead to increased capacity in the north and north-west. But, we cannot offer a proper service in the north and north-west of any kind on 13.5 hours a week for each person.

CHAIR - It is fair to say in our rural communities there is still that high level of stigma and lack of inclusion for people of the LGBTIQ+ community.

Have you any idea of how much that relates not an intent perhaps to discriminate or not to provide an inclusive service, but out of ignorance?

Dr JARVIS - Yes. I think it is patchy. I would never like to say one area of the state is more or less inclusive than the other, because people and communities often surprise you.

There are a few things happening here and some rural communities are more conservative. Some rural communities have higher rates of people of faith, in most communities that are not acceptable of the LGBTIQ+ people. That can have an impact. Sorry, I have lost my train of thought there. What was your question again?

CHAIR - It was really about how much is ignorance. I do not mean ignorance being rude. I mean ignorance as never been exposed to this. I do not know about it and do not know how to respond. A trans person walks toward me, how do I respond?

Dr JARVIS - Of course, because we all grew up not knowing how do this stuff and not being used to it. Yes, in a lot of cases, what we find now is the service for example. Once upon a time, Working It Out, when we did training and so forth, we were probably going into rooms where we had to change people's opinions first, before we could do anything.

Now we go into rooms, most people want to do better. It is about, how do I do better? What does that look like?

As you said before, some people think, 'well I've just got to treat everybody the same'. But in fact, that is not really the answer. There is a need to understand the sum of the particulars about different communities, whether they be called communities or LGBTIQ+ communities. There is some dedicated knowledge you need to have in there and it does not need to be all that complicated either. You are right, it seems a bit weird, people seem to think they cannot acquire this knowledge that somehow, it is this space that is foreign to them. That is also a barrier to overcome. Like, I cannot know about this stuff because I am not gay or trans. I often have quite intelligent people say I just can't get it, kind of thing. And, I think you probably could if you spent a bit of time at it.

Mr GAFFNEY - There is a bit of an issue like 20 years ago it was the LGBI community and then there have been acronyms added and then there are the pronouns you are supposed to use to not offend people. People are just a little bit confused and it does not come naturally. I even have trouble saying LGBTIQ+. It is just that not wanting to say the wrong thing. Actually, I often apologise in advance. So, look if I say something wrong here, it is because of ignorance, not because I want to.

Dr JARVIS - You are right. I am always railing against our silly acronyms that do not do us any favours and get longer and longer. We could say the diverse gender sex and sexuality would be a nice short thing, but we cannot get that to get traction.

You are right there, Mike, but I think you will find that most LGBTIQ+ folk are okay as long as people are trying. The pronoun things are new and it is kind of just creeping into our lives. From my point of view, I am always accepting that people are trying and doing their best and yes, it is new territory.

It is interesting because some people imagine Working It Out, people like myself are out there encouraging people to be trans and gender diverse and all this kind of stuff. Probably the reality is true, we sort of say, 'I'm thinking about this.' But it is young people, young people are just breaking down the boundaries around - particularly around gender. They do not want those categories anymore and so a lot of this stuff is actually being driven by younger people saying, 'No, we're done with this male or female thing,' and it will be challenging for all of us because so many of our societal systems, processes and expectations are created around that

binary. I always try to be respectful and it can be tricky. There are things that people can do and learn to help but as long as people are trying and respectful, they will generally get a good response from LGBTIQ+ most people, not everybody is the reality.

Mr GAFFNEY - The guest speaker you had at The Dorothies was just brilliant.

Dr JARVIS - Rohan, yes, he is pretty great.

Mr GAFFNEY - I just wish that had been videoed for lots of people to see. For him, it was all about people trying. They were all about making mistakes but at least the footy club was trying and the cricket club was trying. He was just brilliant in his speech.

Dr JARVIS - Most of us are like that. If you are trying, you understand that it is confusing and new to you.

Mr GAFFNEY - It is also difficult for some medical staff and health practitioners that have come through a different paradigm of social awareness?

Dr JARVIS - Yes, definitely it can be. Even for younger people coming through. The whole Religious Discrimination Bill was another site of trauma and we have had several sites of trauma this year. The sports debate, which I can see today is back up again. That has been really traumatic but the Religious Discrimination Bill. It got dropped in the last one, but the first two iterations of that bill said health practitioners had the right to deny service to people on the basis of their religious view, which we know is primarily aimed at LGBTIQ+ people. Christian Porter said that quite openly about that bill.

If you live in a rural community and there is one doctor and he is a person of faith who thinks that transgender people should not exist, what do you do? Or that gay males should not have sex and won't prescribe PrEP or HIV preventative medications, then what do you do? It is not as simple as finding another health practitioner because there probably isn't another health practitioner.

CHAIR - It is not always possible to leave town.

Dr JARVIS - Even though that did not get a guernsey in the end, we are going to keep our fingers crossed that certain sections of that bill never get another airing as even the fact publicly funded health facilities, such as hospitals and GPs - they are all publicly funded in some ways - could discriminate in their hiring based on their religious belief, was another issue.

The reason I brought that up, Mike, is a couple of years ago I went to an event at Medical Students for Inclusion and Diversity. I was talking to a lovely young man who was a medical student and it twigged to me because the questions he was asking, obviously he came from a fairly devout Christian background and I asked him, 'Do you think it's okay to deny services to LGBTIQ+ folk based on your faith?' And he, without a hesitation, said, 'Yes.' Even though we think that this is a problem of older generations not understanding and even though I said younger people are forcing change, there are also pockets of resistance within there.

Mr DUIGAN - On the slide, I reckon.

Dr JARVIS - You might say that the Religious Discrimination Bill was a hair's breadth from getting through. Whilst general community attitudes are on the slide, sometimes political outcomes do not always reflect those general community attitudes. You know, I think we've found it's easy to demonise LGBTIQ+ people's lives. From my perspective, yes things are improving and things are great, but I always think it wouldn't take much for things to change again. I don't think we are so - we haven't ingrained this in our culture so much that it couldn't be reversed pretty quickly.

In the US in 2018 there were approximately 38 anti-trans, anti-LGBTIQ+ bills put through the legislature in the US in 2018. Up until the end of May in this year, in the US, there have been 240 anti-LGBTIQ+ bills brought through the legislature in Texas. Supporting transgender children is now considered a form of child abuse. Sorry, I don't think we are that far away from that. Yes, we're pretty good, but it could change at any point.

CHAIR - You've only got to have a look in the challenge to the *Roe v Wade* if you want to see that attitudes perhaps haven't changed in the way they need to.

Dr JARVIS - We're talking about rural health in Tasmania and we were talking then about the US but we're naive to think that those things don't impact. Getting back to the local and the regional is that it is still fragile in those spaces and we don't even have good care yet, but it could certainly get worse as well as get better.

Mr GAFFNEY - So, if you think of extrapolating that position for the community to be well serviced by the THS would show a lot more faith in what we're trying to do here. Instead of just being off the side of your desk, trying to figure out which doctors and nurses and that sort of stuff, and our university may, or may not cover it. It's not part of our culture yet, even though it's improving. There are still things that can be done, heaps of things that can be done.

Dr JARVIS - Yes, there are short-term and long-term actions and so some of those things about a dedicated mental health service, for example, is a good example of short-term action that could make a real difference. Then long term it's that ongoing education, embedding the LGBTIQ+ people's lives as mainstream, as not being 'nothing to look at here' kind of thing. When we are talking about schools, for example, we don't always advocate for huge changes, but you just have us in your curriculum. You have us there as you might have a person with a disability, or you might have a person from another country. So, normalising our lives is really what we want. We don't want to be a big thing. We just want to be part of the community.

Mr GAFFNEY - My last question, I was fortunate I was speaking with the doctor at The Dorothies and she was talking about how in the initial stages it would service the community really well if there was a dedicated suite of rooms, doctors rooms and allied health professionals that would have all the information there. Once it was there then they could start dispersing it through their interaction with their colleagues and that sort of thing. I know we're talking rural health but she was also talking about - and then an outreach program where they could do two days on the west coast or two days around the place. I think Rodney also mentioned that model.

Dr JARVIS - Yes, and I think I put it in - Working It Out, yes.

Mr GAFFNEY - So, that you would be supportive -

Dr JARVIS - Of course, yes, Working It Out, because we've recognised in the mental health space and I know you're talking about the broader health space but they apply equally, we've recognised for some time about that massive gap in the mental health space - in the clinical or therapeutic mental health space. So we're already looking at, 'Well how can we do that? What does it need?' We would be very supportive of something like that, whether it's a holistic health centre with mental health as a part of that and yes, whether we can - you may need to centre it somewhere, but we can have other health staff operating around the state. Yes, that would be fantastic. I think that would be really great.

We never need to take our eye off the preventive side of things as well though, because that's what creates a long-term change. Providing those preventive mental health services and strategies also is really paramount, otherwise we end up in the tricky situation that we're in - like emergency departments if we don't look after the stuff when it's manageable then it ends up as a crisis. So keeping our focus on mental health but then some dedicated services would go a long way to not only providing the needs for LGBTIQ+ folk statewide but also providing a way to educate other practitioners around them as well.

Mr GAFFNEY - Thanks, Lynn.

Mr DUIGAN - In terms of the services you provide and the interactions you have with people in the health space, if you focus on rural health, what's the overarching volume of calls coming in? Is it about mental health? Is there anything in particular that -?

Dr JARVIS - Yes, psychologists - we get asked again and again to recommend psychologists.

Mr DUIGAN - And how do you go? Are there enough of those services?

Dr JARVIS - No, there are no dedicated services.

Mr DUIGAN - Right.

Dr JARVIS - There are a few people who we would say we'd be happy to refer to because we know they're inclusive but there's no dedicated service to refer people to.

We have a bit of a running list that we keep that we would perhaps refer people to and try to get people around those but the other thing, of course, is that people's books are closed.

I think I know the doctor you're referring to, Mike, who you were talking to. She is working with a GP clinic here and is very trans-inclusive, and I'm pretty sure that her books have just gone vroom, filling up really quickly because there are so few of those people around.

Mr DUIGAN - For GP clinics and other clinicians out there in the community, is there a place that they can access? You were talking about THS training provisions. Is there anything for them? Is there a way onto the ladder that they can start providing better services?

Dr JARVIS - Yes. Those resources made by the Department of Health are open to everybody. Anybody can access those, and they just need to contact the Department of Health or at Working It Out we can point them in that direction. We have had discussions but, again, I haven't quite progressed this - haven't had time - with Primary Health Tasmania (PHT)

because they're the people who can get in touch with GPs. I know the Department of Health has been working with PHT around those learning resources so that's great; so that's a good first step.

Mr DUIGAN - Would you say there is an appetite for it or is there a perceived gap in the service? Would a rural GP service understand that they're perhaps not providing an inclusive service?

Dr JARVIS - I don't know. I think it's a bit of the 'I don't know what I don't know' kind of thing. I have a friend who's a GP in Launceston and she says, 'I just treat everybody the same'. I challenged her about that recently and said, well, people come with specific needs; they're not all the same. It is important to understand what people might be presenting with or what challenges or issues they might be presenting with so I think it could be a bit of that too - they don't know what they don't know.

When we do training, we ask people how confident they might feel and a lot of people say,' Oh, yes, pretty confident; I think I know this stuff'. At the end of the session we ask them again and they say, 'Oh, no, well, I didn't realise I didn't know all of those things'. People might overestimate their knowledge in this area a bit.

CHAIR - Just to go back to treating everyone the same but not the same - you treat everyone according to their needs.

Dr JARVIS - Yes, to their needs.

CHAIR - But, if you don't have a really deep and informed knowledge of the needs of - I will go back to a time I looked after an Egyptian woman in labour or a Jewish woman in labour - they have very different cultural needs. If you don't know what they are, then how can you provide that culturally-sensitive care without asking them what is it that you want me to do?

Dr JARVIS - It may be that you do need to ask occasionally because you can't know everything.

CHAIR - That's right.

Dr JARVIS - But even understanding that you might need to ask is really important.

CHAIR - Yes, that's right. That's the difference in providing the appropriate care for everyone. If you don't understand what their need might be, you have to ask.

Dr JARVIS - Yes. There are specific health needs in the LGBTIQ+ community. There are health needs of gay men. There's a campaign for cervical cancer for lesbians at the moment, for example, because for a long time, lesbians were told they didn't need to worry. That's not true so now we have to re-educate everybody. There are fertility issues amongst same-sex couples.

CHAIR - Nuns were told the same thing.

Dr JARVIS - Yes. There is specific information that people need to know as well.

Mr GAFFNEY - Thank you.

CHAIR - Thanks very much for your submission and your evidence today. It was really helpful, we hope to get a report prepared fairly soon.

Dr JARVIS - Thank you for your questions. Many, many things to cover. Thank you.

Committee adjourned at 11.40 a.m.