



Champlain Regional Planning Table for Trans, Two Spirited, Intersexed and Gender Diverse Health Services

Meeting: January 9, 2017. 6 - 8pm

Location: Centretown CHC boardroom, 400 Cooper St., Ottawa

Present:

Community members:

Mikki Bradshaw, Maëlys McArdle, Benny Michaud, Kaeden Seburn, Mel Thompson, Jaina Tinker (via video link), Patricia Vincent.

Trans Health Information Ottawa: Rika Moorhouse, Serena Rivard.

Service Providers: Tammy DeGiovanni, CHEO; James Fahey, Champlain LHIN; Jane Fjeld, Youth Services Bureau of Ottawa (as lead agency for child and youth mental health); Stephanie Hemmerick, Seaway Valley CHC (via video link); David Hesidence, Royal Ottawa Mental Health Centre; Simone Thibault, Centretown CHC (representing 6 Ottawa CHCs)

Rainbow Health Ontario: Devon McFarlane (via video link)

Jane Moloney, Project Consultant

Regrets: Laurie Rektor, Family Services Ottawa

1. Welcome

We would like to acknowledge and honour that we hold this meeting on unceded Algonquin Territory. To be present on this land is an honour and not a right.

2. Turn around times for documents and responses to emails

All agreed that 1 week maximum is required for response to emails, documents for approval etc. in order to keep the project on track. If responses haven't been received within one week approval will be assumed.

3. Approval of minutes of meeting December 11, 2016

Minutes approved with slight amendments. These will now be translated and loaded onto the website once the translation is ready.

All RPT members agreed to have their name included in the list of attendees present at the meeting. In addition, all members agreed to their email addresses being visible on correspondence between group members. Emails will not be forwarded outside the group with community member email addresses on them.

4. Approval of Terms of Reference

Terms of Reference approved. These will now be translated and loaded onto the website once the translation is ready.

5. Bios:

Community Member Bios

Community members can continue to send bios if there is information about who they are and the work and they are doing with their community that they would like to share with the group. The purpose of the community bios is to make up for the lack of time at meetings for everyone around the table to find out more about each other and what they are bringing to this planning work. Community members are invited to have their bios included on the website.

Service Provider Bios.

The purpose for these is different which is why the providers were asked to answer a set of questions (suggested by THIO) that would help community members to know who is making decisions about services and participating in this planning work. There was discussion about putting the service provider bios on the website. The reason for this is to demonstrate transparency and openness to trans, Two Spirited, Intersexed and gender diverse people and to respond to calls for information about who makes decisions about their health, health care and related services.

It was noted that this will be a temporary measure while the website is the main source of information about this work and related services but that, ideally, this information will be available on service provider websites in the future.

Decision: It was agreed that service provider bios would be put on the website. If possible, the listing will just show the service provider's name, organisation and job title with the option for the viewer to read the bio rather than place a lot of text on the page.

Actions:

- Service providers can edit and resubmit their bios to Jane M by January 16th
- Service providers who do not wish their bio to go on the website must let Jane M know by January 16th
- Community members who consent to their bios being put on the website need to let Jane M know by January 16th (so that they can be translated)
- Bios will be sent for translation and loaded onto the website once the translation is ready

6. Service mapping

Draft (sample) questions were circulated to prompt discussion on what the service/asset mapping is trying to assess and what is possible within the scope of this work.

There was lengthy discussion on what the service/asset mapping process is for and how it will inform the business plan.

Sending questions to (cisgender) managers and service directors will not gather provider-specific information but sending questionnaires to individual providers may not result in a good rate of return and therefore we will miss a lot of information.

Timing was discussed and the possibility that the work can be done at different levels with some phasing. Agreed that it is important to start with what is already known and that the community members and service providers at the table can provide a lot of information about who is providing and accessing services (as there is so little available). Important to recognise that a different, more granular and detailed approach may be necessary for rural communities as there may be little or no information about providers who are not well known or well connected.

Assessing cultural competence should not be done by asking organisations or providers to self-assess how well they think they are doing (as this is subjective) but, rather, by using an approach of targeted interviewing with specific questions, examples were provided (updated after the meeting by Benny):

1. How many of your staff have knowledge of traditional medicines and understand the importance smudging has in health and well-being?
2. How many spaces within your organization are there where smudging can occur?
3. Have your staff received training on inter-generational trauma stemming from the residential school system, the sixties scoop, and other colonial policies?
4. Have your staff received training on the traditional role and responsibilities two-spirited people had and continue to have in Indigenous communities?
5. Have your staff received training on how colonial policies have negatively impacted the health and well-being of two-spirited people by degrading their place within communities?

It was suggested that we need to build trust with providers if we want them to show their vulnerability and be open to building their skills and capacity. This will help to be able to identify gaps.

It was agreed that we are looking to establish a benchmark of the existing situation, including experience of barriers to access to service, and identify how far away this is from equity with access to services for the cisgender population (being aware that not all cisgender people have the same access to culturally competent, culturally safe health care and related services).

Considerations could include:

- Who is funded to provide services?
- What are they funded to provide?
- How do service providers self-describe the services they provide and their approach?
- What is their capacity (existing clients, to take on additional clients)?
- What helped you to get to where you are now?
- What challenges are you experiencing doing the work now?
- What would they like to provide?
- What would they need to provide it (funding and other supports)?
- What training have they received?
- What supports are they aware of or able to find for their clients that specifically address the needs of trans, Two Spirited, Intersexed or gender diverse people?
- If they are not providing services for trans, Two Spirited, Intersexed or gender diverse people, what is their openness to this?
- What would they need to provide different levels of services (i.e. more) (funding and other supports)?

There were several suggestions that the more detailed mapping work, including the assessment of cultural competence and awareness of trans, Two Spirited, Intersexed or gender diverse could be a recommended action for the business plan.

A literature review was recommended in order to look at work that has already been done and what standards already exist.

Important to see this as a process of incremental change and that training is only part of the process of change (without follow up people will likely retain and apply ~10 % of what was covered in training). In finding out what has helped people through the process of change we can identify the resources required to support more providers through this process.

The vision is for culturally competent, culturally safe, informed, respectful care, programs and services for trans, Two Spirited, Intersexed or gender diverse people. This vision requires a network of professionals who are 'up-to-date' on current standards of care and are actively participating in a community of practice that is adequately funded to support continuous professional development. Providing care (health; mental health, addictions and concurrent disorders; and social services) for trans, Two Spirited, Intersexed or gender diverse people should be naturalised as part of providers' professional responsibility.

Community members' experience is far from this.

Examples given:

- Provider fear when the word trans is mentioned
- Lack of services, especially mental health, and trans, Two Spirited, Intersexed or gender diverse people being continuously 'referred on'
- Refusal or inability to provide specific care and services related to trans, Two Spirited, Intersexed or gender diverse health care that acts as a barrier to accessing other health care (due to the lost of trust between client and provider)
- Trans, Two Spirited, Intersexed or gender diverse communities relying on each other for information and navigating access to services rather than trusting providers
- Trans, Two Spirited, Intersexed or gender diverse educating providers
- Battles to get referrals from providers to specialists e.g. endocrinology and lack of information on specialists who are competent and knowledgeable to provide quality care for trans, Two Spirited, Intersexed or gender diverse people.
- Lack of informed care (and sometimes lack of willingness to become informed)
- Providers who are not informed of other services (acts as a barrier to receiving referrals to or information about services that are needed)
- Lack of awareness by providers of processes for accessing other services
- Providers and specialists passing patients back and forth because providers don't feel qualified and specialists are overloaded

It was suggested that service mapping may confirm what we know about what services are available but that the conversation and hearing from community members about what we need and where we're at seems much more relevant, important and helpful to providers. This heightens the need for community engagement to assess what is needed and where we are in relation to that.

In summing up, our starting point is that, until now, Centretown CHC has taken the main responsibility for providing primary health care services and there is little or no service at the moment when viewed across the region. There is no assurance or confidence that the services that do exist are clinically and culturally competent, informed, holistic or integrated.

Community engagement is needed to hear the difference between the vision and the experience. Suggested that community engagement focuses on how to grow what is good and to hear about people's worst and best experiences.

Decision: Start with gathering information from all RPT members

Actions:

- Jane M to contact everyone individually to gather what is already known
- Benny will provide wording for cultural competence questions

7. Community Engagement

Agreed that this needs to be started as we will not have time for it if we wait until the next meeting.

Action: Jane will reach out to THIO and others and follow up on suggestions already received for community facilitators for community engagement in order to start the process.

8. University Community Service Learning Placements

- No discussion

9. Dates of future meetings

Dates have been set for two more meetings as sent out in the email with tonight's agenda: **January 23rd 6 - 8 pm and February 13th 6 - 8pm**

Video link will be for a longer period so that we don't get cut off before the conversation has finished.

A Doodle poll will be sent out to set a date for a meeting at the beginning of March.

Please fill in the Doodle poll within 1 week of receiving the invitation email so that the date can be saved in peoples' calendars.