3CR Binary Busting Broadcast  
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*Prisons and Healthcare*

**Tilde:** All right, hi! Welcome, everyone. Thanks for joining the panel today. I thought we'd just start with a quick round of intros, so I'll just start from my left on the video call, and we'll go with Starlady. Hey Starlady, who are you and what do you do?

**Starlady:** Hey, I'm the program manager at the Zoe Belle Gender Collective, and I use she/her pronouns.

**Tilde:** Fantastic. And we've got Elle?

**Elle:** Hi, I'm Elle. I am the peer navigator working for Your Community Health as part of the trans and gender diverse health service there, and I use she/her pronouns.

**Tilde:** Thanks, Elle. And Alex?

**Alex:** Um, hi. I'm Alex, she/her pronouns. I'm a student psychotherapist and, sort of, community mutual aid member and participant, as well as someone who also experiences her own mental health intersection.

**Tilde:** Excellent, thank you. And Asiel?

**Asiel:** Hi, I'm Asiel. My pronouns are they/them. I'm a GP at Northside Clinic and an academic at the University of Melbourne.

**Tilde:** Awesome. Hey, so thanks everyone so much for meeting today. I might just introduce myself. My name's Tilde Joy, I'm a first-year student nurse, and I thought maybe we could start off with, like, talking about just, as a group of trans people, what our experiences have been like accessing healthcare at the moment, and how that might have changed over the last little while, and what kind of gaps we can identify at the moment as – you know, in the provision of healthcare for trans people.

**Asiel:** Yeah, absolutely. I think over the course of the pandemic in particular, what we've seen in primary care is just an absolute overflow of primary health resources, and there is a lot of, I think, complex interactions between that. There's obviously a great demand and growing community need, which we've known, kind of, time and time and time and time again. With Covid in particular, I think a lot of those community supports have just been completely severed and people have really felt the isolation. The difficulty is that the services have not quite kept up with the demand, so whenever I'm seeing patients, clients, I often have to give a long list of, like, doorknocking to see who has capacity to actually just respond.

And similarly, if people require care that's a little bit more intensive, accessing tertiary care, accessing mental health care hospitals, public services is just such a rigmarole. It really requires strong advocacy, not only from primary health providers but also self-advocacy for a lot of the members of the trans and gender diverse community, which, if you're in a vulnerable population, obviously your resources are completely drained around that. So it's been a really difficult time, at least from my own experience.

**Tilde:** Absolutely. And Elle, you're also working in primary healthcare, maybe not – in a different role to Asiel, not a GP, but what have you seen over the last little while?

**Elle:** I mean, trans healthcare's always been pretty, I guess, you know – good trans doctors are always in demand. If someone knows that a doctor is trans‑friendly or uses, you know, the informed consent model, everybody knows who they are in the trans community, and so it kind of, like, can get a bit, I guess, hard to get in with doctors who are known as good doctors. And then there are other doctors who are, I guess, you know, learning, so we are slowly getting more doctors who can provide gender-affirming care, but it is a long, slow process. And I guess it's, yeah, just lots of work.

But I guess particularly over the last year and a half, I've seen a lot of people wanting to access, I guess, gender-affirming doctors and access, yeah, basically just for general health services, and that demand is actually going up a lot more, as opposed to accessing a doctor for just trans‑specific healthcare services. And so yeah, it's starting to reach a critical point, I guess.

**Tilde:** Yeah, and you've been working in trans healthcare for quite a while now, haven't you, Elle?

**Elle:** Yeah, various places, yeah.

**Tilde:** And so have you noticed, like, a shift over the years?

**Elle:** I guess, you know, in the past a lot of the trans healthcare was really around – you had a doctor that was maybe a little bit okay with trans stuff. You know, who didn't make you feel uncomfortable, but couldn't do anything for you because they had no knowledge. And so we're kind of seeing this shift more to, I guess, GPs now actually being able to – and feeling comfortable to provide gender‑affirming care, as opposed to referring to specialists.

**Starlady:** Yeah, I mean, I think we need to acknowledge the history of pathologisation on, you know, trans and gender diverse community, and to acknowledge that pathologisation is still having a massive impact on the trans community and our access to gender-affirming care that puts the health and wellbeing of the trans and gender-diverse community at significant risk. In the last few years, we have been moving towards, or some GPs and the government has been moving towards, models of informed consent around accessing HRT, but, you know, there is a lot of work that needs to happen within the medical industry to depathologise, and there's a lot of work that needs to happen, I guess, in medical education systems to include trans-affirming care. It shouldn't be a specialist care. It's seen as a specialist care, I think, still. But we need all GPs to be taught and to be able and be confident in delivering informed consent. Because until we have health equity, trans and gender diverse health is not going to change. It's not going to improve.

And we need more GPs. There are still so few GPs who are willing to do informed consent that it puts – you know, it delays trans and gender diverse people's abilities to affirm their identity, which we know is a protective factor, we know is an empowering factor. And until that changes, you know, we won't see great improvements in trans health.

But I'd also think – so we've got this history of pathologisation, but I also like to acknowledge what I would call, what the ZBGC is calling a current crisis in trans and gender diverse health. We already had a level of crisis around trans people's mental health, like suicidality and self-harm for our community, in research, is through the roof, and we have tertiary health systems that I think are not just providing poor care, but they are actually dangerous when trans and gender diverse people enter those systems. They often abuse us, or cause significant harms, or they deny us access to those services. And I think we need to hold – the community and the LGBTI sector needs to hold the government and the tertiary mental health system to account, and we need to be demanding changes.

Like, it's great, I guess, there's been the Royal Commission into the Victorian mental health system, but I didn't see pathologisation as a part of that. I didn't see informed consent as a part of that, and it's certainly – it's given vague recommendations around LGBTI inclusive practice, but it has not named anything around developing trans and gender diverse inclusive practice or what needs to happen, and I think this is outrageous that this is happening. And I mean, we've seen deaths in our community over summer that we need addressed, and I just don't see that it's being addressed, and I don't see that the government's taking this, *us*, seriously enough.

**Tilde:** We certainly have. And I think people who – like, I only had a passing acquaintance with Bridget, who passed away over the summer, but every trans person, I think, who heard that news was just shattered when it happened, so we definitely need to come to terms with this stuff. Just before we move on to Alex and maybe your thoughts about some of the gaps, I thought just, for our listeners at home, I think one or two of them might be cisgender: what is the informed consent model, and what did we have before informed consent?

**Asiel:** I suppose historically, a lot of trans and gender diverse identities have been put in this medicalised, pathologised kind of model, where in order for people to access hormone replacement therapy, gender affirmation services, they had to be formally diagnosed, and it typically involved a gender assessment by a psychologist or a psychiatrist, and it typically involved a specialist like an endocrinologist to be able to prescribe that hormone replacement therapy. Informed consent in Australia started coming in about 2014, 2015, particularly at Equinox Gender Clinic, and essentially shifted that focus away from a specialist base type of assessment and a pathologising assessment to a more primary care, community-based kind of assessment.

And the way that I think about it, it's not even an assessment per se. It's a trans individual coming in, we discuss what their goals of gender-affirmation are and how we can best support that particular person. So we're not placing absolutely any value judgment on anyone's identity or gender presentation or gender identity or whatever else it might be. It's very much about working together to support that particular individual in their needs. I would love to hear from Elle's perspective as well. I know you do quite a lot of work in this space, so if there's anything to add, anything to correct, absolutely feel free.

**Elle:** Yeah, definitely. I mean, I tend to describe the informed consent model as kind of developing a relationship between you and your GP. You know, a GP is the person who, I guess, takes on the responsibility of prescribing, and so they want to feel comfortable that if something's happening to them that they don't know how to understand, they're finding struggles with, that the GP knows that they'd come back to them and say, 'Hey, this is going on. Is this to do with being on hormones? Is this something that we could have a conversation about?' So, you know, all the clinicians that I work with, they're all pretty open that, yeah, basically if something's happening and you don't know what's happening, come to your GP. Go to your GP about it. And so, yeah, that's kind of, I guess, the main way that I think about informed consent.

And so I guess the other thing about the informed consent model is that it doesn't explicitly rule out the possibility of secondary consultations. And I think that scares a lot of trans people, is thinking that they're gonna be, I guess, set back if there's a – you know, a secondary consultation is made with another clinician. And I guess, you know, that definitely comes about from the history of pathologisation, where, you know, you're kind of told that you can't move forward until you've done this secondary consultation with someone. And I guess, you know, it is scary, but at the same time, it means that your healthcare is actually being tailored towards you, and that's kind of, I guess, the most important thing about informed consent. It's that, yeah, you're fully informed about what's happening.

**Tilde:** So just rewinding a little bit: Alex, I'm sure you've got some thoughts on what gaps in accessibility and service look like in healthcare at the moment. I was wondering if you could expand on, you know, what you've been working on lately.

**Alex:** Sure, yeah. So yeah, I think the informed consent model – you know, I transitioned just before it kicked in. I had to do a pathology model.

**Tilde:** Same.

**Alex:** And part of me actually kind of likes that. It's like, 'Back in my day, I had to do this.' You know, and I mean, it's a brilliant model. It's pretty amazing. It's essentially allowing so many of us to manifest or to become, and I think what the felt sense for me is is that it kind of ends there. There's this, like, 'Okay, now I get to be trans.' Like, I get to be visible, I get to manifest, I get to become – and then what? It's essentially then a massive gap between any other service of, like, going into hospital or having acute mental health. Also just experiencing what it's like to be complexly impacted every single day by living your identity in a world that isn't entirely friendly. And so I think that, at least for myself and many of my friends, it's producing complex trauma responses in us. We are getting sicker.

You know, the more of us there are, you know, there is a portion of us that are just struggling so deeply within that, and there isn't really available options, and pretty much out of the 20 therapists that I've seen, about two have been, you know, able to hold any space for the complexities of that experience. And I think there's just – I can only really speak from their mental health perspective, it's there's just, like, an incredibly large gap. You know, incredibly appreciative of our medical system for expanding so rapidly and, sort of, really meeting this need, and so many people have been able to access that. And as you were saying before, it's not enough, but, you know, I think it opens these other gaps.

There's other things in and around surgery. Like, I personally went overseas and had a horrid surgery that I'm now like – a trans-affirming surgery that went terribly wrong, and basically nothing I can do about it now because it was done overseas, because it was pushed outside of Australia because we don't have adequate access to safe surgery options here, so it's pretty limited. One of the other contributing factors to mental health issues around being trans.

And I think that begs this question around, if the system is so systemically failing, then how do we as a community respond? I come from the belief that a system – institutional systems are always going to be flawed to some degree. I mean, we can make them better and we can ask them to be accountable, but like, when we think about complex issues like, you know, the pathology of borderline personality disorder and how difficult that is to treat, you know, and particularly something that's pretty rampant within community. You know, the sort of pathology, like, thrown left, right, and centre, and it's something that I question whether it's even something that a therapist could adequately deal with, has been thinking about particularly the deaths in the community and how many people are affected with that pathology, that it's a responsibility in the community, when we're thinking about an attachment regulation disorder or an anguished disorder – I think these are better words for it – it's like that we as a community can hold that space probably ten times better than the institutions. We're waiting, dying, for the institutions to catch up to us, and in the interim, what can we as a community do?

And I mean, I think looking at other countries, the necessity for mutual aid and how radical that can be, like, my perspective is that we create our own solution rather than waiting, rather than dying, for the system to catch up. Let's generate something, a care model, a respite model, a healing model, a recovery-based model, within community, and have leadership in recovery. Big concept, not quite sure how we're gonna really manage that one. But I mean, what I and a bunch of community members just, sort of, in response to the emergency over the summer was to start the idea of HOML, a House of Mutual Learning, which would be like a – the original idea is that it's a place, but I think that's going to take quite some time. To begin with, it's going to be, like, a strategy, basically a trans union within the community, and how to resource each other. Who's got something to give, and who has a need. And so addressing that, and then hopefully building towards actually creating a centre, run by the community for the community. Rather than some sort of government, sort of, *generously* offering us something, like, let's just build it to begin with, is my kind of ethos.

But, you know, I sort of also question that sort of ethos as well. Like, it is questionable. It is complicated. It is flawed, and it's difficult, and we are a hard group of – we're a hard community to care for, invariably, so.

**Tilde:** Well, I think it's such a beautiful idea. And I'm a staunch labour unionist myself, and like, well, it's music to my ears to hear of, you know, the principles behind what you're organising around at the moment and what we hope to get out of it too, so I'm incredibly excited. So I thought we could next move on to, as people who have an involvement in institutions that provide health – I know, Alex, you're a student psychotherapist, I'm a student nurse, we're kind of going through that on‑boarding process of being, you know, brought into the institution. I'm wondering what kind of barriers trans people face in entering the institution in the first place?

**Alex:** It's kind of a bit hard-hitting, just going back to school after quite a large crisis within the community, and talking to my institution on where I'm at, my own mental health has been deeply impacted by this process. And you know, I approached my university and I was like, 'Look, I'm probably struggling. I'm going to be studying with that struggle, and then how do we – how can I struggle and not let go of this course?' And they basically offered nothing. And so there is no – and nothing. They don't even do basic pronouns. Like, there's no introduction. There's no one-on-one. It's basically: the entire responsibility's on me as a student to educate twenty other peers about, like, the basics of pronouns, and it's so simple. And I hate that it's just as simple as that, but like, they're not even doing the fundamental within an institution.

And that's – this problem is that as a trans person, you kind of have to work, you know, five to ten times harder, and it's already hard. And so it's a burden to begin with, and then they give you basically weights to put on your own shoulders, and no wonder, you know, we're not making it up into institutions or, like, manifesting. Like, you know, it's taken me two or three years of severe mental health issues to finally build up to the point to get into the system. Getting into it and then realising it's not very good, and they make me work twice as hard than any other student, and I'm just, like, exhausted by it, and part of me does want to step away from this. Like, I don't want to exist in an institution that doesn't strongly support me and advocate for me. But what else are you supposed to do?

**Tilde:** Yeah, I've noticed very similar things, being the only trans person in my cohort and studying online via Zoom and things like that. But also within, I think, just the institution itself, if we're talking about birth-giving, it's always like 'mothers' and 'she' and 'her', and, you know, if we're talking about toileting, you know, if a patient has a penis then they're immediately assumed to be a man, and things like that. And even, like, the whiteness of the institution too. Like, I noticed they're teaching us about, like, what the correct skin colour for someone who's well-perfused should be, and it's, you know, pale and pink, which is not necessarily true. Asiel, you stand at the intersection here between transness and being a person of colour. What kind of barriers have you noticed as a practitioner within health institutions?

**Asiel:** Where to even start! I mean, a lot of the work that I do now in terms of academic work is very much around challenging all of those systems of knowledge. I just very vividly remember one of the places that I trained in. You know, people who are in power, people who were kind of the head of that particular institution, saying, 'Oh, you know, if you ever showed up to work in a dress, none of the patients would respect you. It would just be incredibly unprofessional,' et cetera, et cetera. Now I make a point to show up every day in the clothing and presentation that makes me feel comfortable, and to hold teaching positions and to get into the educational space in a very similar way, so no other student feels like, you know, there's no trans people in healthcare, or you can't be trans and a healthcare professional, because there's a lot of systemic barriers already kind of put in place.

And with that in mind, the other thing that is really difficult to contend with is absolutely that white kind of lens that's layered on top of all of this kind of teaching. So even though there are some leeways that are being made, and there's small progress around, I don't think we have a very good answer of how to have a really robust kind of educational system or institution that takes these things into account. We're always very much coming from kind of a cis, heteronormative, patriarchal, white, colonial kind of lens, and anyone who enters, not only a teaching institution but those healthcare environments, has to, in a way, subject themselves to it in order to access the care that they need.

So I think that's a big, big question that I don't think the medical system in itself has come up with an answer to. It's something that constantly needs to be challenged and chipped away kind of bit by bit. And I am hoping that as time progresses that, you know, people from community get into those positions of power, we make more space, we bring people up with us to really allow that institution to change from the inside out. But it's difficult. It takes a lot of time. It takes a lot of energy. It takes a lot of emotional labour to get there.

**Tilde:** It certainly does. So maybe Starlady and Elle, kind of, interacting with the health institution, not directly as practitioners but, you know, through things like Zoe Bell and being the peer liaison, what's your perspective on the challenges it takes for trans people to have a say in their own healthcare?

**Starlady:** Well, I think first of all, I think in acknowledging the poorer health outcomes for trans and gender diverse people, it's not a trans issue. It's our society's issue. It's our society's problem. And until our society addresses our cisnormativity, you know, homonormativity – no, heteronormativity! [Laughter] You know, all these things, until we address those things, our health and wellbeing outcomes aren't going to change. We need to be – our society needs to be addressing transphobia. We need to be addressing the stigma and violence that is occurring towards trans people. We need to be breaking down the rigid gender stereotypes that trans and gender diverse people are forced – you know, and the gender binary, we need to be breaking these down, and that's happening – what needs to happen on a societal level.

We also need to be breaking down the barriers for trans and gender diverse people in affirming their gender identity. Socially, legally, medically, culturally. And until those things change, trans health and our outcomes won't really change. I think, you know, in a sort of pathologising lens, so many mental health practitioners and practitioners work from a lens that trans people are, you know, experiencing gender dysphoria. Parts of gender dysphoria, I would really question. Is gender dysphoria a symptom of transphobia and cisnormativity within our society? And sometimes the idea of gender dysphoria places the blame and internalises it within trans people, but are we actually the problem? And I think mental health practitioners, to be really able to support and work with us, need to understand, have an in-depth understanding of the sort of, like, barriers, obstacles, pressure, discrimination that trans and gender diverse people can face. Because until you know that, how can you unpack that with a trans and gender diverse client?

And so we need to be seeing, I think, a much higher level of education, in particular of mental health practitioners, into 'what does transphobia look like', 'what does cisnormativity look like'. And until you can work from that framework, you're not going to be able to have a genuine therapeutic practice with a trans person if you are saying to them, you know, 'How can I help you with your problem', because it's not actually our problem. It's a societal problem. Yes, we might need support in how can we be resilient in the face of this incredible amounts of discrimination and stigma, but it's not our fault that we might have poorer mental health. That's society's problem.

**Elle:** Yes. Some of the other things that I consider, you know, a barrier to entry into the system is a lot of people tend to treat accessing healthcare as a passive act. You know, as an act where they attend an appointment with a doctor because they have an issue that the doctor's going to help them fix, and so, you know, often will go into appointments expecting that they're gonna know best. And I guess parts of that continue, even though we learned to educate our medical professionals on pronouns, talking about gender affirmative language. That's been a big thing that has been put on a lot of trans people, and so while that's starting to be the area that's been focused on – you know, we're teaching clinicians how to use affirming languages – it still doesn't address an issue that a lot of people expect that their clinician is gonna know best.

**Tilde:** Yeah.

**Elle:** And so, you know, they're not asking the questions that they should be asking. They're not saying, 'Hey, this is actually the direction I want to be going in. This is – you know, this is something that I want to talk about before we actually do this.' I guess an example of that would be, you know, expecting the doctor to know the best type of medication for yourself, when the truth is that there's multiple different medication types, and you should be talking with a doctor about which one's going to be best for you. You should be able to feel comfortable to ask, 'Hey, I've heard some things about this one. Can we talk about, you know, the alternatives, and can we talk about, yeah, what's going to work best for me?'

**Tilde:** And I think that joint decision-making's so important. And yeah, this stuff has such an impact, right down to, like, reception staff understanding what a deadname might be and why not to say it out loud in the reception room and things like that. And, you know, this is one thing that we can tackle in primary healthcare, you know, but if you're going to see a physio or a psych or, you know, any other number of, like, specialist services, that's just training and relationships that I think remain to be built.

**Starlady:** I mean, they don't even know how to – healthcare professionals broadly don't even know how to manage the confidentiality of trans and gender diverse people, and often, you know, out them and put their safety at risk, and they don't know how to manage trans people's referral letters. Do they write the name on the Medicare card? Do they write their affirmed name and their affirmed pronouns or what? They're not even having those conversations. I would say that broadly, healthcare is really failing trans and gender diverse people, and they don't even have the basics in order, let alone the sort of, like, really high-level trans and gender diverse practice. And that really needs to change, and it needs to come back to our medical – you know, our medical institutions giving their students better training across the board.

**Tilde:** So I think you made a very good point earlier, Starlady, about the emphasis on dysphoria, and I think in an earlier conversation we've talked about, you know, within practice, we don't really talk about gender euphoria and what we can do to make trans people happy. And I thought just going from that, we've talked a lot about the problems in healthcare as an institution, but maybe we could just do a round of, like, what would be the best thing we could see in healthcare, and what's a perfect outcome for trans people that we would like?

**Starlady:** I'll just chuck in, God, I'd really love to see more peer workers. And the peer workforce, so it's like trans and gender diverse people, you know, being able to support members of our community, and for us to be treated with the respect and dignity that we deserve within that system, rather than often peer workers within our health institutions are sort of looked down at and have a much lower status, and we don't have significant amounts of power and authority. So, like, you know, healthy equity and equity for peer workforce.

**Elle:** Yeah, I was gonna say, that being kind of explicitly what my job is, you know, I think that it would be fantastic if there was a lot more people who were doing the exact same work that I do. You know, doing that, being the face that someone talks to at the first appointment they have at a clinic, you know, where they can actually go, 'Trans people are respected here. Trans people are put into important positions.' Yeah, just I think there's a lot more work than just the small amount of peer workers that are working now in these professional capacities. Yeah, there's just so much more work. And I guess I don't want to discount the role of, I guess, peer support outside of those organisations, because there are plenty of people who, you know, I guess, talking about mutual aid, there are people who definitely do the same work that myself as a peer navigator does, but aren't employed within an organisation. That's important work too, but at the end of the day, those people should be receiving a pay cheque for what they do.

**Tilde:** Do you want to receive a pay cheque, Alex?

**Alex:** Um, yeah, maybe three months full-time, 24-hour. Yeah, over the last three months I've been practicing under, like, 'what would I want, and how do I be what I want in a system?' And when someone said to me, 'I want to go to hospital, I don't feel safe,' and I sat down with them over a cup of tea and said, 'How do we do that?', and we wrote a list, and then I went in with them and I advocated for them, next to them, each step of the way, like, consenting and consulting and checking in, both with her and her partner, both trans people in quite a difficult situation, and advocating for them, and getting her in a hospital bed in in-patient care. Or coming across people and seeing the need and then meeting it, you know, by someone who is trans, who understands the system, who understands the mental health issue itself, someone who's experienced, has expertise, lived expertise in and around mental health crisis, and then helping someone activate what they need to do it safely, and providing interim care. Like, people have stayed in my house. I took someone to hospital, and they just basically said that they had no available beds and they could wait in the ED after they had made, you know, efforts against living that same day.

**Tilde:** Jesus Christ.

**Alex:** Me coming, and they'd had a police call – police check on them by their therapist, who was also queer. I took them to hospital and was refused a bed, basically, and I was like, 'Well, you're coming home with me,' and I already had someone staying with me. And there's a big question about the ethicacy in and around, sort of, like, 'well, come over' – like, doing that kind of work, and I question my own ethic in that, and I do think it's complicated, but the people that I have supported over the last three months, like, the people who took in crisis care with me experienced a way better interaction with the mental health system. Each person, you know, got what they needed to get what they needed, and they're on a process of recovery, and they have a network of friends now. Like, they stay at my house. They get someone visiting every single day. They had meals dropped off. They didn't have to think about things. I even organised a massage for someone – and myself, because I deserve that too. If I'm going to care that hard, I need to care for myself that hard.

And like, I personally would love me right now to come in and look after me, because I've just, sort of, worked myself a little bit too hard. You know, as someone who doesn't really receive an income for any of this work, it would be lovely to be looked after in that way, but I know that my network and community current – my direct friends have kind of, like, after a couple of weeks of my own mental health, are kind of struggling, so having someone with a lived trans experience come in and be like, 'What can we do?' And instead of saying, 'No,' or saying, 'That's not what we do,' it's like, 'How can we help?'

That's the thing I'm always looking for, is, like, how can we help, and that's not what we have. It's like you go in and, 'We don't have any beds. We don't have this. You have to go on a waiting list. You have to go CATT team.' What the fuck is CATT team? Like, what have they ever done? Like, how much money are they getting? Like, it's absolutely ridiculous. So yeah, I want more trans people. I want people fucking standing up for each other and looking – sorry for swearing.

**Tilde:** No, no, that's fine.

**Alex:** Looking out for each other and radically caring for each other. And I'd love for there to be employment pathways. I'd love for that to be then, like, how you get a job in the mental health system, not through, you know, years of study under a system, but years of lived experience, and modelling actual job pathways. Because I mean, just some bloody jobs would be great too, you know?

**Tilde:** Yeah.

**Alex:** There's so many bloody issues, and I think we could quite easily fix them. With the problem we have, we could fix that with the problem, you know, like …

**Tilde:** Yeah.

**Alex:** Yeah. Anyway, that's my …

**Tilde:** Yeah. I think every trans person going through that deserves that kind of care, and I'd love to make that real. How about you, Asiel? What would you like to see?

**Asiel:** Well, first I would echo absolutely everything that was already said before around it. There are so many competing priorities, I wouldn't even know where to start. I would 100% agree on just the mental healthcare system really needs to be thrown out the window and then revamped, and kind of recreated around – it's such a problematic system to work in, work with, enter. Just all of those aspects around it make it really, really difficult in certain cases. It's kind of the risk factor even in and of itself. You know, if you were having a difficult mental health time before, after engaging with the system, a lot of the times it comes out kind of worse. That's one element of things. And I think all the wonderful solutions that Alex has mentioned are incredibly, incredibly important. Having that community autonomy and leadership is vital.

I suppose kind of stepping back to, kind of, a broader systems-type of overview around it, I would echo what Star mentioned before. I think medical education just really, really, really needs to be re-done. And in a certain way, it's been frustrating how slow the progress has been around it, because we know that this is such a huge community need, and, you know, my repeated message around it is that if we have all of those basic core competencies from the very beginning, no matter what role that particular health professional is going to play in the future. They're going to have at least the basics to work and advocate and not become part of the problem, if that makes sense, not exacerbate those barriers. And I think that needs to apply across all medical specialties, of specialties whatever else. We don't need just, kind of, more inclusive GPs. We need more inclusive everyone. We need a more inclusive system, period. And from my perspective, medical education just needs to be an integral part of doing that.

So if I had one wishlist, I suppose it would be to kind of completely re-do the medical system so it doesn't come from that cis, heteronormative, colonial, patriarchal lens around it. How do we go about getting that? I think education's one of them. Obviously community voice and leadership is another element around it. But really, the systems that are there need to work with us to make that a reality, and I absolutely value all the advocacy that people like Star, like Elle, like Alex are doing, because it's just so, so, so, so vital.

**Tilde:** That's about all we've got time for. Thanks so much everyone for joining us. We're going to have some links up on our social media and also our website – that's 3CR.org.au/binarybusting – and they're going to point towards the House of Mutual Learning's fundraiser, because they're raising some money at the moment to help set up that project. And yeah, thanks everyone for joining. We've had Starlady from the Zoe Bell Gender Collective, we've had Elle Void from Your Community Health, Dr Asiel Adan Sanchez from the Northside Clinic, and Alex Calf from the House of Mutual Learning. Thanks so much everyone for joining.