Health and wellbeing for
lesbian, gay, bisexual, trans, intersex [LGBTI]
people and sexuality, genders, and bodily
diverse people and communities
throughout Australia

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Religious Discrimination Bill: Second Exposure Draft

National LGBTI Health Alliance submission

31 January 2020

About the National LGBTI Health Alliance

The National LGBTI Health Alliance (the Alliance) is the national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on lesbian, gay, bisexual, transgender, and intersex people (LGBTI) and other sexuality, gender, and bodily diverse people and communities. Our mission is to provide a national focus to improve health outcomes for LGBTI people through policy, advocacy, representation, research evidence, capacity building and national coordination.

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Introduction

The Alliance welcomes the opportunity to provide feedback on the federal government's *Religious Discrimination Bill 2019: Second Exposure Draft* (the Bill). This submission will build upon our initial submission made in October 2019 and reiterate our support for removing discriminatory access barriers to healthcare for LGBTI people.

We would like to take this opportunity to endorse the submissions and recommendations provided by our sector partners Equality Australia, Australian Federation of AIDS Organisations, and Intersex Human Rights Australia, and respectfully ask that there is consideration given to the potential health and wellbeing implications on LGBTI people and their families as a result of a prolonged national dialogue on this issue.

The Alliance's position

The Alliance supports the federal government's commitment to provide comprehensive protection from discrimination for people of faith in areas of public life, provided that these laws do not sanction and enable new forms of discrimination against LGBTI people. We have long advocated for reducing discrimination, stigma and violence against LGBTI people, their families and their communities, in an effort to improve overall health and wellbeing and reduce continuing harmful health disparities. Whilst we acknowledge minor improvements to provisions relating to conscientious objections for healthcare practitioners, we believe that overall the Bill continues to legitimise discrimination against LGBTI people, privileges the religious views of healthcare practitioners over patient needs, and entrenches double standards in law.

Our key concerns include:

- **Sections 8(3) - (5)**, which make it easier for people to offend, insult, intimidate and humiliate others outside the workplace.
- **Sections 8(6) and (7)**, which allow doctors, pharmacists and other health care practitioners to refuse to provide services to patients.
- **Section 42**, which exempts "statements of belief" from all Commonwealth, State, and Territory anti-discrimination laws and allows discriminatory comments to be made my religious individuals in all areas of public life.

This submission will closely examine the above provisions, and provide key recommendations to ensure the Bill strikes the right balance in providing fair and balanced protections from discrimination for all people, including LGBTI people.

Health and wellbeing of LGBTI people

LGBTI Australians have demonstrated considerable resilience in looking after themselves and their communities despite adversity. Many live healthy and happy lives, contributing to their families, local communities, workplaces and society as a whole. Nevertheless, an overwhelming amount of research evidence has consistently demonstrated that LGBTI people experience significant health disparities compared to the general population. These poorer health outcomes can be attributed to the impact of Minority Stress - the chronic stressors that LGBTI people are uniquely exposed to as a result of sexuality, gender and bodily diversity being socially stigmatised. This includes experiences of discrimination, social exclusion, harassment and physical violence.

Specifically, compared to the general population, LGBTI people are in their lifetime more likely to attempt suicide, have thoughts of suicide, and engage in self harm. Younger people are at particular risk with LGBTI young people aged 16-27 being five times more likely to attempt suicide than their peers.

LGBTI people are also at higher risk of a range of mental diagnoses and are more likely to be diagnosed with anxiety and depression, and psychological distress. Lesbian, Gay and Bisexual people are twice as likely to have symptoms that the criteria for a mental health disorder in the past 12 months, with 24.4% of LGBTI people currently meeting the full criteria for a major depressive episode.[1]

It is unknown how many LGBTI die by suicide due to the lack of standardised questions regarding sex, gender, gender identity, sexuality, and intersex status in suicide death data records. However, the increased rates of poor mental health, and related suicide thoughts and behaviours leads to the conclusion that LGBTI people would undoubtedly be at a heightened risk of death by suicide.[2]

There is a clear and demonstrable relationship between abuse and harassment, and psychological distress. LGBT people aged 16 and over score an average K10 score of 19.6, indicating moderate psychological distress[3], which is higher than the general population average score of 14.5 indicating low psychological distress. However, LGBT people who have experienced abuse and harassment scored an even higher average K10 score of 22.83, indicating a high level of psychological distress.

This is true also for experiences of abuse related to feelings of being unsafe, self-harm and suicide in same-gender attracted and gender diverse young people aged 14 to 21 years. 22% have had thoughts of suicide, and 8% have attempted suicide which is already significantly higher than their peers (which is 3.4 and 1.1% respectively), but thoughts of suicide jump to 30% for those who have experienced verbal abuse, and 60% for those who have experienced verbal abuse. Suicide attempts also increased with abuse, with 18% for those who have experienced verbal abuse, and 37% for those who have experienced verbal abuse.[4]

Rather than being isolated incidences, 39.5% of LGBT people reported experiences of harassment and abuse, 66% of people with intersex variations had experienced discrimination from strangers ranging from indirect to direct verbal, physical or other discriminatory abuse[5]. 61% of same-gender attracted and gender diverse young people have experienced verbal abuse, and 18% physical abuse.[6]

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[1] Hyde, Z., Doherty, M., Tilley, P.J.M., McCaul, K.A, Rooney, R. & Jancey, J. (2014). "The First Australian National Trans Mental Health Study: Summary of Results." School of Public Health, Curtin University, Perth.
[2] National LGBTI Health Alliance, (2016). "National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A New Strategy for Inclusion and Action." Available from: https://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB.pdf
[3] Hyde et al. (2014)
[4] La Trobe University, (2010). "Writing Themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people." Available from: https://www.glhv.org.au/sites/default/files/wti3_web_sml.pdf
[5] Jones, T., Hart, B., Carpenter, M., Ansara, G., Leonard, W., and Lucke, J. (2016). "Intersex: Stories and Statistics from Australia." Available from: https://interactadvocates.org/wp-content/uploads/2016/01/Intersex-Stories-Statistics-Australia.pdf
[6] La Trobe University, (2010). "Writing Themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people." Available from: https://www.glhv.org.au/sites/default/files/wti3_web_sml.pdf

It is vital to note that LGBTI Indigenous and Torres Strait Islander people who are also LGBTI, Sistergirls or Brotherboys experience a number of significant and intersecting points of discrimination and marginalisation. These include structural, institutional and interpersonal forms of discrimination based on race, gender, colonialism, and LGBTI status. As a result, Indigenous LGBTI people face further challenges in relation to their overall mental health and social and emotional wellbeing.[7]

LGBTI people also have specific experiences when it comes to alcohol and drug use and mental health. It is clear that members of LGBTI communities use alcohol, tobacco and other illicit drugs at elevated rates compared to the broader population and are significantly more likely to experience drug dependence. The 2016 National Drug Strategy Household Survey found that illicit drug use in the last 12 months was more common among people who identified as homosexual or bisexual (42%) than among heterosexual people (14%). This pattern was seen across all age groups. Considering only those people with high or very high psychological distress, homosexual or bisexual people were more likely to smoke cigarettes (35%), consume an average of more than 2 standard alcohol drinks per day (28%) and engage in illicit drug use (51%) than heterosexual people (29%, 22%, and 27%, respectively).[8]

It has been suggested that many LGBTI people use these substances as part of a coping strategy to deal with discrimination and difficulties that LGBTI people regularly experience, that there may be a normalisation of substance use in some LGBTI social settings, and that people who identify as being homosexual or bisexual are generally more accepting of regular adult use of drugs than people who are heterosexual[9].

Access barriers in receiving welcoming, equitable and inclusive healthcare

Australian and international research has shown that LGBTI people underutilise health services and delay seeking support due to actual or anticipated discrimination or stigma from service providers. For example, in Private Lives 2, 34% of LGBT Australians reported "usually or occasionally" hiding their sexual orientation or gender identity when accessing services to avoid possible discrimination and abuse.[10]

The Trans Pathways study found that 42.1% of trans young people encountered mental health and other medical services who "did not understand, respect or have previous experience with gender diverse people." Further, 60.1% of study participants experienced feelings of isolation from these

[7] Australian Human Rights Commission, (2015). "Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights." Available from: https://www.humanrights.gov.au/sites/default/files/document/publication/SOGII%20Rights%20Report%202015_Web_Version.pdf

[8] Australian Institute of Health and Welfare, (2016). "The National Drug Strategy Household Survey 2016: Detailed findings." Available from: https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true

[9] Leonard, W., Lyons, A., and Bariola, E. (2015). "A closer look at private lives 2: addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians." Monograph series no. 103. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.

[10] Leonard, W., Pitts, M., Mitchell, A., Lyons, A., Smith, A., Patel, S., et al. (2012). "Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians." Monograph Series Number 86. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

services, which was found to be linked to higher rates of self-harm, suicidal thoughts, suicide attempts, and diagnoses of PTSD and anxiety.[11]

In 2014, the From Blues to Rainbows report asked 188 trans and gender diverse young people their reasons for not seeing a health care professional. Among the reasons were fears that they wouldn't be understood (33%), the language used by health professionals made them feel uncomfortable or angry (23%), and negative past experiences (30%).[12]

Further, the Australian Human Rights Commission's Resilient Individuals Report found that nearly 25% of respondents in the online consultation reported being refused a service of some kind on the basis of their sexual orientation, gender identity and/or intersex status.[13]

It is important to note that people born with variations in sex characteristics have experienced trauma and stigmatisation in healthcare and this may limit their utilisation of necessary health and medical services. Schützmann and others (2009) reported an Australian study as showing rates of psychological distress similar to "a comparison group of chronic somatically ill persons", thus showing "markedly increased distress" in people born with variations in sex characteristics.[14]

The SWASH Survey, a biennial study of lesbian, bisexual and queer women showed that those respondents who were out to their regular GP were more likely to be very satisfied (49%) than those who were not out (30%).[15] That is, disclosing sexuality appeared to be associated with a more positive relationship with their GP or health service.

Meaningful consideration of the significant health disparities experienced by LGBTI people, and the multiple barriers that currently discourage them from accessing the healthcare they need is crucial to adequately responding to policy proposals that risk having an adverse impact on the health and wellbeing of LGBTI people and their families.

Religious anti-gay prejudice as a predictor of poor health outcomes

Researches from Macquarie University in Sydney recently examined whether religious based anti-gay, or homonegative, prejudice had a detrimental impact on the health and wellbeing among lesbian, gay, and bisexual (LGB) individuals as well as their heterosexual counterparts. The results of their empirical study, published in the peer-reviewed American Journal of Orthopsychiatry in 2017 demonstrated that exposure to religious anti-gay prejudice (the disapproval of homosexuality on religious grounds) predicted higher levels of anxiety, depression, stress, and shame; more harmful alcohol use; and more instances of both physical and verbal victimisation. These harmful outcomes

[11] Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., et al. (2017). "Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results." Perth: Telethon Kids Institute.
[12] Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A., and Hiller, L. (2014). "From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia", Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.
[13] Australian Human Rights Commission, (2015). "Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights." Available from: https://www.humanrights.gov.au/sites/default/files/document/publication/SOGII%20Rights%20Report%202015_Web_Version.pdf
[14] Schützmann, K., Brinkmann, L., Schacht, M. et al. Arch Sex Behav (2009). "Psychological Distress, Self-Harming Behavior, and Suicidal Tendencies in Adults with Disorders of Sex Development." *Archives of Sexual Behavior*. 38:1. pg. 16–33.
[15] Mooney-Somers, J., Deacon, R.M., Scott, P., Price, K., and Parkhill, N. (2018). "Women in contact with the Sydney LGBTQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2014, 2016, 2018", Sydney: Sydney Health Ethics, University of Sydney.

were observed among both LGB individuals as well as heterosexual individuals, regardless of whether these individuals were religious themselves.[16]

These key findings have profound implications pertaining to policy and legislation relating to religious freedoms, specifically the Religious Discrimination Bill, for the following reasons:

- The disapproval of homosexuality on religious grounds amounts to more than just a harmless expression of one's religious beliefs. Rather, significant harm ensures when religious bodies, organisations, and people of faith espouse, or expose others to, anti-gay messages in the public sphere.
- Provisions that facilitate and legitimise the expression of anti-gay prejudice on the grounds of religious belief will pose broad and significant threats to overall health and wellbeing of sexual minority populations.

> "[L]egal and institutional discrimination, as well as ballot measures and referendums that incite debate around the civil rights of sexual minorities, are likely to leave individuals increasingly exposed to anti-gay stressors and experiences of prejudice that occur outside of their control... Prejudice may be further facilitated through exemptions to anti-discrimination policies that allow religious businesses and institutions to deny employment, academic enrollment, or the provision of goods and services to sexual minority individuals. The current findings suggest that policies purporting to protect religious freedoms are likely to do so at the expense of sexual minority wellbeing, insofar as these policies legitimize expressions of prejudice on the basis of anti-gay religious beliefs."[17]

Overall, these findings highlight the extensive and pervasive nature of the adverse health and wellbeing implications associated with anti-gay religious exposure, given the variety of deleterious outcomes this kind of prejudice predicted, and insofar that it extends to non-religious LGB individuals and heterosexuals more broadly.[18]

'No Consequences for Conduct' - Section 8(3) - (5)

The Alliance believes that provisions relating to indirect discrimination in Section 8 are unnecessarily complex and go well beyond the standard indirect discrimination test articulated in other anti-discrimination legislation. Furthermore, they undermine the ability of large employers to promote diversity and equality in their workplaces and elevate religious rights above the rights of LGBTI people to be free from discrimination.

The Alliance acknowledges that the provisions relating to employee conduct rules, Sections 8(3) – (5), apply to a reduced set of circumstances, namely protecting employees in conduct "other than in the course of the employee's employment". However, we are of the understanding that the provisions have been extended to include professional qualifying bodies, in addition to large private sector employers.

The insertion of the new clause 8(4) clarifies that a qualifying body cannot impose a rule restricting or preventing a person from making a "statement of belief" other than in the course of their profession, trade, or occupation, unless it is an "essential requirement" of the profession, trade or occupation. Previously, bodies that conferred professional qualifications may have reasonably denied admission or registration to an applicant due to harm caused to the reputation or mission of

[16] Sowe, B. J., Taylor, A. J., & Brown, J. (2017). "Religious Anti-Gay Prejudice as a Predictor of Mental Health, Abuse, and Substance Use." *American Journal of Orthopsychiatry*. 87:6. pg. 690-703.
[17] Ibid
[18] Ibid

the organisation, or to staff, customers and clients, or the potential to undermine public trust in the profession.

Everyone should be free to express themselves outside the workplace environment, irrespective of their religious beliefs. Any limits placed on employers and professional bodies should be reasonable, balanced, and fair and not legitimise the privileging of certain views over others. The Alliance is concerned that this clause will allow degrading or demeaning public comments about LGBTI people to be said outside the workplace, with limited or no professional consequences.

It is well documented that LGB employees who experience minority stress in the workplace report poorer mental health outcomes[19] and decreased job satisfaction and commitment.[20] [21] Studies on the workplace experience of LGB people have documented that fear of discrimination and concealment of sexual orientation is prevalent.[22] These studies showed that LGB people engage in identity disclosure and concealment strategies to avoid experiences of discrimination. These strategies include passing, which involves lying to others in order to be seen as heterosexual, and covering, which involves censoring one's behaviour, expression, or history to conceal their sexual identity. This constant vigilance when interacting with others for fear of harm and expectation of rejection result in poorer health outcomes for LGB people.[23]

Therefore, the Alliance recommends the removal of Sections 8(3) – (5) of the Bill to ensure that workplaces across Australia are safe and inclusive places for everyone, including LGBTI people.

Recommendation 1: Section 8(3) - (5) of the Bill should be removed.

Conscientious objections in health care - Section 8(6) and (7)

The Alliance acknowledges the minor improvements to the 'conscientious objection' provisions in the Second Exposure Draft. This includes narrowing the range of health professionals who can take advantage of these sections to nurses, midwives, doctors, psychologists and pharmacists, and that the objection must be to providing in a particular health service, and not an objection to the personal attributes of the person seeking the service. Despite these changes, the Alliance believes that the provisions continue to entrench discriminatory access barriers to culturally safe and high-quality health care for LGBTI people. This is enabled by allowing medical professionals responsible for the most essential healthcare to refuse to undertake procedures, or provide information, prescriptions, or referrals that are related to services that are most commonly or exclusively used by members of LGBTI communities. For example, hormone treatment for trans and gender diverse people and the dispensing of Post Exposure Prophylaxis (PEP) or Pre-Exposure Prophylaxis (PreP) to gay men and other men who have sex with men.

[19] Velez, B. L., Moradi, B., & Brewster, M. E. (2013). Testing the tenets of minority stress theory inworkplace contexts. *Journal of Counseling Psychology, 60,* 532–542. https://doi.org/10.1037/a0033346
[20] Button, S. B. (2001). Organizational efforts to affirmsexual diversity: A cross-level examination. *Journal of Applied Psychology, 86*, 17–28. https://doi.org/10.1037//0021-9010.86.1.17
[21] Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: Fear and disclosure of sexual orientation at work. *Journal of Applied Psychology,92*, 1103–1118. https://doi.org/10.1037/0021-9010.92.4.1103
[22] Croteau, J. M. (1996). Research on the work experience of lesbian, gay, and bisexual people: An integrative review of methodology and findings. *Journal of Vocational Behavior, 48,* 195–209.
[23] Waldo, C. R. (1999). Working in a majority context: A structural model of heterosexism as minority stress in the workplace. *Journal of Counseling Psychology, 46,* 218–232.

Healthcare research has demonstrated that being out to your regular GP is conducive to increased positive health outcomes. Therefore, as explicated in a range of government health strategies, there is a vital need to work with LGBTI people in a culturally safe way. Fear of discrimination, such as withdrawal of care, may lead LGBTI people to have difficulty disclosing even where they believe these issues are directly relevant, to the detriment of their care.

For example, a gay man concerned that a condom broke during a recent sexual encounter who asks his doctor to prescribe him post-exposure prophylaxis (PEP) within the 72-hour window, may be refused access to any sexual health services by his doctor because his religious beliefs forbid sexual activity outside of marriage. Under the proposed Section, it will be too late for the clinic to debate whether the patient's health needs should trump the doctor's personal religious views. A refusal to, or a delay in, assessing an individual's appropriateness to receive HIV prevention technologies will needlessly expose individuals to feelings of anxiety associated with a HIV diagnosis, and add pressure to the healthcare system to manage the lifetime treatment and medical costs associated with managing a person diagnosed with HIV.

The first Australian Trans and Gender Diverse Sexual Health Survey found that better access to medical gender affirmation is associated with lower psychological distress and increased sexual and romantic satisfaction.[24] Trans and gender diverse people already face significant, unnecessary barriers in navigating the health system in order to receive gender affirming care. The above provisions will undermine efforts to increase access to gender affirming care for trans and gender diverse people, which will have a negative impact on their overall health and wellbeing.

Additionally, the Alliance is concerned that the above provisions are extended to include health services that the professional *participates* in, not only services that they provide themselves. This would potentially enable a doctor, nurse, pharmacist or psychologist to refuse to refer a patient to another practitioner who will treat them or provide information about a treatment which is available that they object to on religious grounds. This undermines principles of a 'no wrong door' approach in the healthcare system.

A universal health care system that is publicly funded should be guided by a 'no wrong door' approach where every Australian has access to a range of quality and affordable health care services from multiple points of entry as needed. This includes LGBTI people. Effective integrated care and robust referral pathways will reduce access barriers and enhance support for LGBTI people who are already subject to marginalisation and stigma. This is crucial in addressing the disproportionately poorer health outcomes that LGBTI people experience.

Further, the explanatory notes states that:

> *"…subclause 8(7) provides that a health practitioner conduct rule is not reasonable unless compliance with the rule is necessary to avoid an unjustifiable adverse impact on the ability of the person imposing the rule to provide the health service, or on the health of any person who would otherwise be provides with the health service" (at 181).*

The explanatory notes illustrate that if a particular health practitioner conduct rule could result in the death or serious injury of the patient, this would amount to an unjustifiable

[24] Callander D, Wiggins J, Rosenberg S, Cornelisse VJ, Duck-Chong E, Holt M, Pony M, Vlahakis E, MacGibbon J, Cook T. (2019). The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings. Sydney, NSW: The Kirby Institute, UNSW Sydney.

adverse impact. However, it then adds that "other types of risks or impacts" to patient health, such as an inability to access alternative healthcare promptly without significant travel and cost, *may* also amount to unjustifiable adverse impact. Therefore, it is not clear what adverse impact on patient care will be justified under this Bill. For example, refusing hormone treatment to trans and gender diverse patients in rural and regional settings where access to gender affirming care is limited.

Despite assurances to the contrary, the Alliance is concerned that Section 8(7) will allow health practitioners to exercise their conscientious objection in a manner which directly affects the patient, causes disruption to patient care or intentionally impedes patients' access to care. Any adverse impact on patient care is unjustifiable.

Note 1 under subclause 8(7) clarifies that a requirement to comply with a health practitioner conduct rule that is not reasonable under this subsection is also not an inherent requirement relating to work for the purposes of the inherent requirements exception in clause 32(7). The Alliance believes this will make it harder for clinics, hospitals and other practices to ensure continuity of care for their LGBTI patients.

Existing State or Territory laws that allow a health practitioner to conscientiously object have carefully considered the impacts this has on patient care. Balancing the right to manifest one's religious beliefs with the right to non-discrimination should result in equitable access to any publicly-available health service. Despite minor amendments, the above provisions still fail to strike that appropriate balance, and undermines current government efforts to reduce access barriers in social and healthcare services for LGBTI people, and work with them in a culturally safe way. The removal of these provisions will have no effect on current laws that appropriately accommodate the personal religious of beliefs of healthcare professionals without undermining the best interests of the patient. Thus, the Alliance recommends that Section 8(6) and (7) should be removed.

Recommendation 2: Section 8(6) and (7) of the Bill should be removed.

"Statements of belief" – Section 42

The Alliance is concerned that the amended provisions relating to "statements of belief" will legitimise discriminatory comments against LGBTI people, which will have a negative impact on their overall health and wellbeing.

The Alliance understands that Section 42(1) of the Bill clarifies that a "statement of belief" does not constitute discrimination for the purpose of any anti-discrimination law, including the *Fair Work Act 2009* (Cth) and Tasmania's best practice *Anti-Discrimination Act 1998*. However, the Bill states that only written and spoken statements (and not refusals to provide a service) will be captured. We are concerned that the above provision will permit people of faith to make discriminatory remarks whilst providing a service to LGBTI people, including in healthcare settings.

For example, a trans woman who seeks a referral from her GP to a specialist to discuss affirming her gender identity may be told by her doctor that "God made humanity male and female, and, in his creative purposes, biological (bodily) sex determines gender". Under the proposes laws, the patient could have her discrimination protections taken away to

accommodate the religious statement, while the doctor may be able to challenge the requirement imposed on him to provide non-judgemental care.

In addition, whilst we recognise that statements of belief which threaten or seriously intimidate others are now excluded from protection, intimidatory statements that are "moderately" intimidatory will be legally permissible under this Bill.

Also, the Bill lowers the bar on what is considered a religious doctrine, tenet, belief or teaching, thereby broadening the definition of what constitutes statements of belief. This will provide special protection to more unorthodox and extreme beliefs.

The Bill undermines existing state discrimination laws by preventing state tribunals from hearing anti-discrimination cases where the respondent has raised the "statements of belief" defence. State tribunals cannot consider issues of federal law, so many state-based disputes would have to be litigated in the federal courts instead, which is a more costly and timely route.

The Alliance acknowledges that statements which are malicious, likely to harass, threaten, seriously intimidate or vilify or which encourage serious offences, will not be protected. However, it still remains unclear what would constitute discriminatory statements against LGBTI people under this Bill.

Examples of statements that may be protected include:

- A boss saying to his employee that homosexuality is sinful.

- A doctor telling a trans patient that God made men and women and attempts to affirm their gender are wrong.

Overall, Section 42 of the Bill risks legitimising degrading and demeaning comments to be made about LGBTI people in all areas of public life. Therefore, the Alliance recommends that Section 42 of the Bill be removed. Conventional discrimination protections would adequately protect the ability for people to express their faith by requiring any restrictions on religious expression at work, school and in the provision of goods and services to be reasonable.

Recommendation 3: Section 42 of the Bill should be removed.

Conclusion

The Alliance would like to thank the Attorney-General for the opportunity to provide a submission to the Religious Discrimination Bill 2019 Second Exposure Draft, and for taking into consideration our key concerns and recommendations. If you require any further information, please do not hesitate to contact myself on (02) 8568 1123 or via email at nicky.bath@lgbtihealth.org.au or the Policy and Research Coordinator Daniel Comensoli on (02) 8568 1132 or daniel.comensoli@lgbtihealth.org.au.