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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Attorney-General's Department
Human Rights Unit, Integrity Law Branch, Integrity and Security Division
3-5 National Circuit
Barton, ACT 2600

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To Whom It May Concern

Re: Religious Discrimination Bill 2019 – Exposure Draft

The National LGBTI Health Alliance (the Alliance) welcomes the opportunity to provide a written submission to the federal government's Religious Discrimination Bill 2019 Exposure Draft (the **Bill**). The Alliance's submission will primarily have a health focus with recognition of the fact that much of the Bill's complexities sit within a legal framework, and thus we rely upon the submission provided by Equality Australia to respond to these issues in more detail. We would like to take this opportunity to 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 religious freedoms.

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.

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.

The Alliance understands that the Bill in its current form contains a small number of provisions that undermine the overall orthodoxy of the Bill, introduces unnecessary complexity, unfairly broadens

the scope of legal protections for religious bodies and people of faith, and privileges religious interests over the interests of LGBTI people to be protected and free from discrimination. Consequently, the Bill currently does not strike the right balance in providing fair and balanced protections from discrimination for all people.

Our key concerns include:

- **Section 8(3) and (4**): it will be harder for large employers to foster an inclusive working environment for LGBTI people through imposing reasonable employee conduct rules on religious expression outside of work hours.
- **Section 8(5) and (6):** conscientious objections for health practitioners will act as discriminative barriers to LGBTI individuals in accessing healthcare services.
- **Section 10:** broad exemptions for religious bodies, including religious schools, religious charities and other religious bodies engaging in religious discrimination will undercut protections for LGBTI people against harmful religious discrimination.
- **Section 41**: certain statements of beliefs will contravene existing federal, state, and territory anti-discrimination protections for LGBTI people, making it more difficult for LGBTI people to participate in areas of public life, such as in the workplace, schools and in the provision of goods and services.

While we have concerns with regard to the pre-mentioned provisions, this submission will examine more closely the provisions relating to conscientious objections for healthcare practitioners set out in Section 8(5) and (6).

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]

[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.

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]

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

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[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
[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

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 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]

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[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.

[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.

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 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.

[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.

[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.

- 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]

Conscientious objections in health care (Section 8(5)-(6))

Despite Australia priding itself in having a universal health care system, fundamental structural shortcomings remain, preventing the health system from providing high quality, inclusive and accessible services and support to LGBTI people and communities. These barriers are further compounded by intersectionalities with overlapping communities including Aboriginal and Torres Strait Islander People, culturally and linguistically diverse people, people with disabilities, people living in rural, regional and remote locations, children and young people, and older people.

It also must be noted that misconceptions and assumptions about intersex are still pervasive, and this has a significant impact on perceptions. Some intersex people are more visible due to innate physical variations of sex characteristics, and as a result are more likely to experience discrimination and stigmatisation within healthcare settings. This is harmful and hinders the accessing of services including healthcare.

The Alliance believes that the proposed rules on conscientious objections in Section 8(5)-(6) of the Bill are overly broad and have the potential to significantly impact on efforts to increase and improve access to GPs, primary health care, and allied health services for a number of sub-populations, including LGBTI people.

The Alliance is concerned that the definition of a "health service" in subclause 5(1) and covers a wide range of health professionals including: Aboriginal and Torres Straight health practitioners, dentists, doctors, nurses, pharmacists, optometrists, occupational therapists, psychologists, podiatrists and physiotherapists. Further, the provisions fail to specify the type of health service in which a conscientious objection may be considered appropriate, for example, a pharmacist declining to dispense hormones to a transgender customer or a GP declining to prescribe PrEP or PEP to a gay man based on a personal religious conviction.

The explanatory notes state that a health practitioner conduct rule should not be limited unless there would be an "unjustifiable adverse impact" on third parties, such as the practitioner's employer and potential patients. Non-compliance with a conduct rule that "could result in the death

[17] Ibid
[18] Ibid

or serious injury of the person seeking the health service" would amount to an unjustifiable adverse impact under these provisions (at 146). This imposes a higher legal bar for the test of reasonableness in determining indirect discrimination, than other indirect discrimination provisions. This leaves it unclear as to whether the imposition of the following requirements will be lawful:

- an obligation to refer a patient if a practitioner objects to treating them on religious grounds; and
- an obligation to treat a patient if the patient's health needs cannot be promptly met by another practitioner, due to significant travel and/or cost.

Lastly, the Alliance is concerned that under these provisions, employers of health professionals may be subject to concurrent complaints of discrimination from: (1) patients or customers who have been denied treatment or a service on the basis of their sexual orientation, gender identity, and/or intersex status; and (2) employees who complain that a workplace policy to provide health services to LGBTI people is an unreasonable condition and contradicts their religious beliefs.

Overall, these provisions have the potential to unintentionally undermine efforts currently underway to provide inclusive services to LGBTI people, and work with them in culturally safe way. For example, our understanding of the Bill is leading us to believe that aged care providers will have to accommodate the conscientious objections of their workers on the basis of their religious beliefs, thus allowing workers to decline attending government-led culturally appropriate training delivered by LGBTI organisations across Australia.

Further, enshrining discrimination and further cementing access barriers to healthcare in legislation will have the unintentional and undesirable consequence of deterring government efforts to reach its ambitious goal of "zero-suicides" in Australia. The healthcare provisions have the real likelihood of adding to the determinants that already place LGBTI people at a higher risk of suicide than their non-LGBTI counterparts.

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.

A universal health care system that is publicly funded should be guided by a 'no wrong door' principle 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. A 'no wrong door' approach 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.

The Alliance recommends that Sections 8(5) and (6) of the Bill be removed. 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. These clauses fail to strike that appropriate balance. The removal of these provisions will have no effect on current laws that appropriately accommodate personal religious beliefs without undermining the best interests of the patient.

Recommendation 1: Section 8(5) and (6) of the Bill should be removed.

Recommendation 2: Section 8(3) and (4) of the Bill should be removed.

Recommendation 3: Section 41 of the Bill should be removed.

The Alliance would like to thank the Attorney-General for the opportunity to provide a submission to the Religious Discrimination Bill 2019 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.

Yours Sincerely,

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