

*Parliamentary Joint Committee on Human Rights
Inquiry into the Religious Discrimination Bill 2021*

Answers to Questions on Notice

Senator Pratt

- 1) Yes, thank you. I want to ask if the health unions, and perhaps also the ACTU, could look at the evidence given by the Council on the Ageing about the conflicted situation that staff could be put in when they are trying to prioritise the need for patient care, according to their professional ethics, and the organisation they work for has religious views about the nature of that care—noting in particular the issues in aged care, where there is not an exemption under the Sex Discrimination Act and all services must be provided to residents on the basis of non-discrimination, and issues that might also arise for workers in other settings where they're trying to maintain professional ethics but they work for businesses or organisations where religious beliefs of the owners or managers might be predominant in the ethos of the business or organisation—if these amendments were to be brought into law.**

The ACTU and the ANMF have reviewed the COTA submission (#29) and the evidence of Mr Irlam given on 21 December. We support the concerns raised by COTA about the impact of aspects of the Religious Discrimination Bill on the delivery of services to older people in religious run aged care and hospitals (sections 8, 9 and 15), as well as their concerns that the bill will elevate one protected attribute (namely religious belief or activity) over other protected attributes (section 12).

The ACTU and health unions strongly agree with COTA that organisations delivering services on behalf of the Government should not act in a manner that is inconsistent with Australia's anti-discrimination laws. We share COTA's concerns that the Bill will undermine this principle. For example, as noted by COTA and the submissions of the ACTU and the ANMF, many organisations have codes of conduct that require all workers to provide health services in a safe and ethical manner, with sensitivity to the needs of the patient or client. As noted by COTA and the submissions of the unions, the effectiveness of such codes will be cast into doubt if the Bill becomes law. The restrictions on qualifying bodies in s 15 will limit the ability of regulators to take action to enforce appropriate standards of conduct, and s 12 will allow religious statements of belief to override all other discrimination laws. For example, the *Sex Discrimination Act* currently says that government funded religious aged-care providers cannot discriminate in their service delivery. However, the Bill will allow staff and managers of such organisations to make discriminatory statements. As COTA points out, the way in which these provisions will operate in workplaces is very unclear. An employer's capacity to take effective action to manage discriminatory and harmful behaviour is made very uncertain by this Bill. This will cause confusion and conflict in aged care facilities, potentially undermining patient-centred care.

- 2) In addition, I wanted to ask the ACTU to consider the effectiveness of existing antidiscrimination law in businesses where people might work and where there are strong religious beliefs being made—not just at an individual level but at a broader, organisational level—and whether the existing protections might be undermined.**

If passed, the *Religious Discrimination Bill* will undermine existing protections by exempting religious statements of belief from all other discrimination laws; and this will apply in all workplaces – both religious and non-religious. There are already existing exemptions which permit religious organisations to discriminate against workers and others. Concerns have been raised by numerous parties, including the union movement, that these existing religious exemptions limit the rights and freedoms of others in a way which is not reasonable, proportionate, justified or necessary. The majority of faith-based organisations do not want or need to single out particular staff members or students for discriminatory treatment in order to uphold their religious beliefs. As outlined in the submissions of our affiliates, these existing exemptions are already causing significant harm to workers. Existing exemptions are currently under review, and no new exemptions should be created before the problems with existing exemptions are fixed.

The *Sex Discrimination Act* and the *Fair Work Act* should be amended to remove the capacity for religious schools and organisations to unfairly discriminate against staff, students and people who rely on services they provide to the public; with urgent consideration given to a new, nationally consistent mechanism which allows competing or conflicting human rights to be fairly, consistently and appropriately balanced. Religious organisations have the right to act in accordance with the doctrines, beliefs or teachings of their faith, subject to limitations necessary to protect public health, safety or the fundamental rights and freedoms of others. No worker should be unlawfully discriminated against by their employer because of their religion, unless religion is essential to the role, and the discrimination is reasonable and proportionate in the circumstances.

Senator Rice

- 1) *Actually, the first one's for the ACTU and the ANMF. Both of you mention, in your submissions, your support for an integrated approach—a human rights act or something of the kind. I wanted to get your response to your support for a charter of rights and a response to the criticism we had yesterday that trying to do that is too hard and it's just pushing it off into the long grass. I also wanted to get your response to an approach of introducing conventional antidiscrimination legislation now, with religion as a protected attribute, and then beginning work on the development of a charter of rights.***

The lack of federal protection against discrimination on religious grounds is only one gap in Australia's anti-discrimination law framework that needs addressing. Our anti-discrimination and human rights framework as a whole is in urgent need of review and reform.

In particular, existing exemptions in anti-discrimination laws urgently need reform to ensure they are fair and meet community standards. The debate regarding the *Religious Discrimination Bill* has revealed the weaknesses in our current system of exemptions. The interaction between religious freedom and non-discrimination is a point of ongoing tension, and existing exemptions (as well as the new exemptions proposed in the Bill) fail to strike a fair or appropriate balance between the two sets of rights. This matter needs urgent attention.

In addition, there are many other shortcomings with Australia's anti-discrimination law regime that need careful consideration, including the suitability of the 'comparator' test, the absence of positive duties to eliminate discrimination, and the effectiveness of complaints processes. The ACTU would support a holistic consideration of Australia's anti-discrimination regime to address these matters comprehensively and make our laws stronger and more consistent overall, including consideration of a new, nationally consistent mechanism which allows competing or conflicting human rights to be fairly, consistently and appropriately balanced.

The ACTU would support the introduction of a conventional anti-discrimination bill protecting against discrimination on religious grounds – either as part of a holistic review project or separately. The ACTU would also support consideration of options for a national Human Rights Act or Charter, including a review of the effectiveness of the current parliamentary scrutiny process.

2) *My other question to the ACTU: I was interested in the statement you made about the risk that employers could take action ostensibly on religious grounds but actually as a cloak to discriminate against workers who are taking action in workplaces on other issues and whether you've got some more evidence of that risk.*

Despite protections in the *Fair Work Act* and Work Health and Safety laws, while many employers do the right thing, discrimination, bullying and victimisation of workers who take on roles at work such as union delegate or health and safety representative (HSR) still occurs in workplaces regularly. For example, a 2021 ACTU survey of workers found that 44% of HSRs have experienced some level of increased intimidation by management as a result of their role, with at least 10% experiencing regular intimidation or bullying. Workers in non-standard and precarious employment are particularly vulnerable: see for example, evidence provided to the *Victorian Inquiry into the Labour Hire Industry and Insecure Work Final Report*, August 2016 at p 129.

The Bill, if passed in its current form, will provide 'cover' for employers to who wish to discriminate against a staff member for taking on a role such as union delegate or HSR. In circumstances where that staff member does not share the same religious beliefs as their employer, the Bill (at sections 7 – 11) provides a very wide scope for adverse action to be taken against the staff member, ostensibly because of their religion. These provisions will mean that workers in religious organisations with differing religious beliefs to their employer will have little protection at work. The rights to discriminate provided by the Bill appear to extend not just to giving priority to applicants of a certain faith in recruitment practices, but to any kind of discrimination in employment on religious grounds, including refusing an existing staff member a promotion or a pay-rise, or terminating their employment. The Bill will give significant power to religious employers to dictate via a policy document what a particular religious ethos or teaching must mean to individual workers. This will go well beyond requiring all workers to be of a certain religion; it will extend to pledging specific support for traditional marriage or opposition to abortion for example. Some religious employers have extremely detailed policies on their religious ethos. Under the Bill, employees could be required to sign up to every aspect of such a policy in order to keep their jobs, even where this was not at all relevant to their role. For example, a part-time Muslim cleaner working in an aged care facility could be fired or have shift cuts or be refused a promotion if she was unwilling or unable to sign a statement committing her to detailed Catholic religious principles, even if this was not at all relevant to her work. It would be very easy for an employer wanting to get rid of a worker taking action for better health and safety at work for example, to demote or fire that worker ostensibly because their religious beliefs differed from the employer's beliefs.

The exemptions are too broad and the protections and safeguards in the Bill are not sufficient to ensure that these exemptions will not be used to victimise workers who stand up for better rights at work.

3) *My questions to the ANMF: Firstly, I was really interested in the concerns you outlined in your submission about the health impacts of statements, supposedly made in good faith, that you describe as 'detrimental, exclusive or offensive to ... gender and sexually diverse people'. I wondered whether you've got any further evidence, in addition to what was outlined in your submission, about the health impacts of those statements.*

Debate concerning the current iteration of the Religious Discrimination Bill and its potential impact upon Australians across healthcare, aged care, schools, and in society more broadly could not come at a worse time. The intensification of the COVID-19 pandemic and catastrophic, widespread impact on every facet of health and aged care access and delivery means that this Bill's likely negative impacts on the health and wellbeing of particularly gender and sexually diverse (GSD) Australians would strike a destructive blow to a vulnerable population who already experience worse access to health care, poorer physical and mental health outcomes, and higher rates of loneliness and social isolation than other members of the community.

The Religious Discrimination Bill takes away existing anti-discrimination protections, including on the grounds of race, religion, sex, marital status, disability, sexual orientation, gender identity or intersex status. Employees, patients, students, and people accessing goods and services may not be protected under existing anti-discrimination laws where a person makes offensive, uninformed, insulting, demeaning or damaging statements based in or about religion. Statements which are malicious, that harass, threaten, intimidate or vilify, or which encourage serious offences, will not be protected. But where the line will be drawn between statements made in 'good faith' that are allowed and those which are not is unclear. This is because the purpose of this clause is to allow people to say, write and communicate things which could be discrimination today. This will perpetuate and foster unsafe environments within and beyond health and aged care for GSD Australians who already experience worse health and wellbeing outcomes in comparison to cis-gendered, heteronormative populations.^{1,2,3} This is likely in part due to different rates of risk factors that cause various physical and mental health problems as well as due to poorer engagement and access to screening, treatment, and supportive services.^{4,5,6,7,8}

To highlight how a community's views and beliefs regarding GSD people can detrimentally impact upon people an Australian study sought to measure the mediating role of perceived social support in explaining the association between structural stigma and the life outcomes of GSD people in relation to the 2017 same-sex marriage plebiscite.⁹ The study found that in electorates with higher levels of stigma/greater percentages of voters who did not support same sex marriage, the health and wellbeing of GSD people was worse than in electorates with lower percentages unsupportive voters. These findings have significant implications for policy and practice, highlighting the need for efforts to reduce community levels of structural stigma rather than implementing a Bill that would protect those who make offensive, uninformed, insulting, demeaning or damaging statements based in or about religion. Qualitative studies have also shown the extremely negative impact that the plebiscite had on GSD people, revealing that GSD participants experienced the Australian Marriage Law Postal

¹ Perales F. The health and wellbeing of Australian lesbian, gay and bisexual people: a systematic assessment using a longitudinal national sample. *Australian and New Zealand Journal of Public Health*. 2019;43(3):281-7.

² Lyons A, Hill A, McNair R, Carman M, Bourne A. *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society; 2020.

³ McKay B. Lesbian, gay, bisexual, and transgender health issues, disparities, and information resources. *Medical Reference Services Quarterly*. 2011;30(4):393-401.

⁴ Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*. 2010;100(10):1953-60.

⁵ Simoni JM, Smith L, Oost KM, Lehavot K, Fredriksen-Goldsen K. Disparities in physical health conditions among lesbian and bisexual women: A systematic review of population-based studies. *Journal of Homosexuality*. 2017;64(1):32-44.

⁶ Roxburgh A, Lea T, de Wit J, Degenhardt L. Sexual identity and prevalence of alcohol and other drug use among Australians in the general population. *International Journal of Drug Policy*. 2016;28:76-82.

⁷ King M, Semlyen J, Tai S, Killaspy H, Osborn D, Popelyuk D, Nazareth I. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 2008;8:70.

⁸ Plöderl M, Tremblay P. Mental health of sexual minorities: A systematic review. *International Review of Psychiatry*. 2015;27(5):367-385.

⁹ *IBID* [1].

Survey debate as a pervasive and predominantly negative event.^{10,11} GSD people have reported experiences of prejudice and discrimination and increased fear, anxiety, anger, and depression. They also described the harm and hurt caused by widespread negative images of and messages about GSD people. Some people even felt their lives were under threat and reported psychological distress and thoughts of suicide. Many GSD people experienced the debate on same sex marriage and vote as a highly stressful, socially fracturing process that threatened interpersonal relationships with family members, workmates, and communities. Many GSD people also described feeling betrayed by the government, country, and Church.¹²

GSD people face substantial barriers to accessing help. Experiences of past and ongoing stigma against GSD people is a known barrier for this vulnerable population to accessing help when needed.^{13,14,15,16} Stigma can be experienced explicitly, when one encounters negative regard through statements or policies, or implicitly, when one perceives negative regard in more subtle ways. Both forms of stigma are pervasive across many Australian contexts including workplaces, health, education, and the wider community. Research has found that GSD individuals are twice as likely as straight people to experience a life event characterised by stigma and prejudice.

Experiences of stigma and prejudice are likely to be more common if those who are discriminatory against GSD people on the basis of religion or faith are protected by the Bill to make offensive, uninformed, insulting, demeaning, or damaging statements made as 'statements of belief'.

There are a variety of ways that GSD people can react to stigma.¹⁷ People may hide their identity from others to avoid harm or may internalise experiences of stigma which can lead to negative mental health outcomes including depression, anxiety, substance abuse disorders, and suicide.^{18,19,20}

Experiences of stigma also erode a person's resilience and ability to cope with stressful life events and contribute to feelings of loneliness and isolation that can impact upon people of all ages, but particularly adolescents,²¹ young people,²² and older adults.^{23,24}

¹⁰ Ecker S, Rostovsky SS, Riggle ED, Riley EA, Byrnes JM. The Australian marriage equality debate: A qualitative analysis of the self-reported lived experience of lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ) people. *International Perspectives in Psychology: Research, Practice, Consultation*. 2019 Oct;8(4):212.

¹¹ Anderson JR, Campbell M, Koc Y. A qualitative exploration of the impact of the marriage equality debate on same-sex attracted Australians and their allies. *Australian Psychologist*. 2020 Dec 1;55(6):700-14.

¹² IBID [1]

¹³ Taylor J, Power J, Smith E, Rathbone M. Bisexual mental health: Findings from the 'Who I Am' study. *Australian Journal of General Practice*. 2019;48:138-144.

¹⁴ Strauss P, Cook A, Winter S, Watson V, Toussaint D, Lin A. *Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results*. Perth: Telethon Kids Institute; 2017.

¹⁵ Rostant J, Leonard W, Jones T. *Health and wellbeing of people with intersex variations: information and resource paper*. Melbourne: Victorian Department of Health and Human Services; 2019.

¹⁶ Mizock L, Mueser KT. Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*. 2014;1(2):146-58.

¹⁷ Perales F, Todd A. Structural stigma and the health and wellbeing of Australian LGB populations: Exploiting geographic variation in the results of the 2017 same-sex marriage plebiscite. *Social Science & Medicine*. 2018 Jul 1;208:190-9.

¹⁸ Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 18, 174 (2019). <https://doi.org/10.1186/s12939-019-1082-3>

¹⁹ IBID.

²⁰ McNair, R., A. Pennay, T.L. Hughes, S. Love, J. Valpied, and D.I. Lubman, *Health service use by same-sex attracted Australian women for alcohol and mental health issues: a cross-sectional study*. *BJGP Open*, 2018. 2(2): p. bjpgopen18X101565.

²¹ DeLonga K, Torres HL, Kamen C, Evans SN, Lee S, Koopman C, Gore-Felton C. Loneliness, internalized homophobia, and compulsive internet use: Factors associated with sexual risk behavior among a sample of adolescent males seeking services at a community LGBT center. *Sexual Addiction & Compulsivity*. 2011 Apr 1;18(2):61-74.

²² Eres R, Postolovski N, Thielking M, Lim MH. Loneliness, mental health, and social health indicators in LGBTQIA+ Australians. *American Journal of Orthopsychiatry*. 2021;91(3):358.

²³ Perone AK, Ingersoll-Dayton B, Watkins-Dukhie K. Social isolation loneliness among LGBT older adults: Lessons learned from a pilot friendly caller program. *Clinical Social Work Journal*. 2020 Mar;48(1):126-39.

²⁴ Sharek DB, McCann E, Sheerin F, Glacken M, Higgins A. Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland. *International journal of older people nursing*. 2015 Sep;10(3):230-40.

Hiding GSD identity can itself be a barrier to accessing safe, timely, and effective healthcare as this means that health and aged care staff are unaware of personal details related to health and wellbeing that may be critical to the provision of care or the identification of relevant health risk factors.²⁵ Due to fear of discrimination, GSD people may even avoid accessing helpline services where face to face interaction does not occur which is particularly concerning during the pandemic.²⁶

The following quotes (bold emphasis added) from GSD research participants illustrate some of the harmful experiences faced when accessing healthcare where how staff and health professionals speak, behave, and treat them can be harmful, discriminatory, and lead to worse care and outcomes. In each of these quotes it can be seen that the participants clearly felt discriminated against by healthcare staff and were hurt in the absence of an overt or aggressive act of discrimination:

*"It became very uncomfortable and **he proceeded to discuss how specific STDs afflict 'my kind.'** I didn't even care about my sickness; I just wanted to leave".²⁷*

*"Your doctor may assume that you're female, and say "okay let's talk about your sexual practices, do you sleep with a lot of men?" **Just that automatic assumption of your gender, and the automatic assumption of your sexuality, and the automatic assumption of your sexual practices is also discrimination. It limits access to healthcare, and that affects health...**when I was a young queer kid, and I felt like when I went to the doctor, my doctor was discriminating against me because of my sexual orientation, or gender identity, I would stop going to the doctor."²⁸*

*"**There's nothing worse than feeling judged by your healthcare provider...**when I went to get a prescription for birth control, I had a male nurse practitioner, and I could totally be reading this wrong, but **the way he said it, it was just like so much disdain.** I just felt so weird, and then he left and my doctor came in and it was fine, but it just made me so uncomfortable. Here I am trying to be proactive, and I'm getting judged."²⁹*

*"And **having to worry about is she homophobic and will she take another snip out of me that she's not supposed to?** I mean, it's crazy, but you do have those thoughts: **Is this doctor homophobic, and will he treat me equally or she treat me equally?**"³⁰*

*"...you don't want to be shunned away from the only place that you can go... You know what I mean? Like, what if you got into a support group, came out [as a lesbian], and then had to deal with homophobia on top of everything else? Then you'd be left with no place to go. So **it's almost better to go and hide, or not go at all, than deal with the stigma.**"³¹*

²⁵ Rossman, K., Salamanca, P., & Macapagal, K. A Qualitative Study Examining Young Adults' Experiences of Disclosure and Nondisclosure of LGBTQ Identity to Health Care Providers. *Journal of homosexuality*, 2017; 64(10), 1390–1410. <https://doi.org/10.1080/00918369.2017.1321379>

²⁶ Lim G, Waling A, Lyons A, Pepping CA, Brooks A, Bourne A. The experiences of lesbian, gay and bisexual people accessing mental health crisis support helplines in Australia. *Psychology & Sexuality*. 2021 Apr 2:1-8.

²⁷ IBID [25].

²⁸ Logie CH, Lys CL, Dias L, Schott N, Zouboules MR, MacNeill N, Mackay K. "Automatic assumption of your gender, sexuality and sexual practices is also discrimination": Exploring sexual healthcare experiences and recommendations among sexually and gender diverse persons in Arctic Canada. *Health Soc Care Community*. 2019 Sep;27(5):1204-1213.

²⁹ IBID.

³⁰ Boehmer U, Case P. Physicians don't ask, sometimes patients tell: disclosure of sexual orientation among women with breast carcinoma. *Cancer*. 2004; 101(8): 1882- 1889.

³¹ Sinding C, Barnoff L, Grassau P. Homophobia and heterosexism in cancer care: the experiences of lesbians. *Can J Nurs Res Revue canadienne de recherche en sciences infirmieres*. 2004; 36(4): 170- 188.

***“They were barred by discrimination even before entering through the door, but before being in there...outside, you see? They were discriminated against. I usually hear the complaints after they go out there, saying ‘I’ll never put my feet in there again because I was discriminated against’.** A stare like this, and other people laughing.”*³²

*“The system of healthcare really has, in some ways, it’s not set up to help transgender people. And so knowing that, like, I can’t change my legal sex, because I still need to get Paps. And that’s the one part that still tied to my old identity is, and that’s the only reason that I can’t do it is that it’s tied to my healthcare. And so um, I think it’s, it’s those thought processes that actually make getting Paps harder, **because it again reinforces how there’s, it’s kind of institutional discrimination that happens against trans people, and how we’re not visible and how we’re not seen.**”*³³

*“Knowing that a healthcare provider was trustworthy and knowledgeable about transgender issues opened the door to communication about cervical cancer screening. ‘Like, if I were to go somewhere new, having to, like, you know, come out to a whole set of new medical professionals would be a barrier. Like, I might say to myself, ‘you know what? **I’m just going to not do it because I don’t want to have to, like, explain my story, and like, I don’t want to have to come out.**’”*³⁴

From a United States’ study; among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:³⁵

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Among transgender people who had visited a doctor or health care providers’ office in the past year:³⁶

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.

³² Gamariel F, Isaakidis P, Tarquino IAP, Beirão JC, O’Connell L, Muliéca N, Gatoma HP, Cumbe VFJ, Venables E. Access to health services for men who have sex with men and transgender women in Beira, Mozambique: A qualitative study. PLoS One. 2020 Jan 30;15(1):e0228307.

³³ Peitzmeier SM, Agenor M, Bernstein IM, McDowell M, Alizaga NM, Reisner SL, et al. “It can promote an existential crisis”: factors influencing pap test acceptability and utilization among transmasculine individuals. Qual Health Res 2017; 27 (14):2138–2149.

³⁴ Alizaga NM. Minority stress, cervical cancer screening behaviors, and gender affirming healthcare among transmasculine individuals [doctoral dissertation]. Washington, DC: George Washington University; 2017.

³⁵ Mizra SA, Rooney C. Discrimination Prevents LGBTQ People From Accessing Health Care. Center for American Progress. 2018. Online: <https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/>

³⁶ IBID.

- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
- 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

It is virtually impossible to find qualitative research around the care experiences of transgender individuals that does not discuss discrimination and micro-aggressions. The 2008–2009 National Transgender Discrimination Survey revealed that 28% of participants postponed medical care due to discrimination and that 28% had experienced harassment or violence in a medical setting.³⁷ The 2015 US Transgender Survey revealed that 33% of respondents stated they had experienced a negative encounter in health care in the past year (including harassment, being refused care, and needing to educate providers about how best to care for them) and 23% avoided health care out of fear of mistreatment.³⁸

Underutilisation and avoidance of health and social services from lack of engagement with preventive health interventions, non-participation in cancer and mental health screening, and delay or avoidance of treatment and support services for mental and physical illnesses contributes to gender and sexually diverse people experiencing worse physical health and wellbeing outcomes in comparison with the wider community.³⁹

Another issue that is linked to worse health and wellbeing outcomes among GSD people is the fact that many health and social services are neither designed nor tailored to be inclusive or meet the needs of GSD.⁴⁰ Because gender and sexually diverse people may have different needs and preferences for health and social care - from the issues they may be dealing with regarding mental health, differences in clinical presentations and clinical treatments due to gender affirming procedures, to needs and preferences regarding aged or disability care – many ‘mainstream’ services are not appropriate, effective, or safe.⁴¹ While there has been an increase in services targeted towards GSD people, these are still not common, are mainly clustered in a few large population centres, and often still only focus on certain members of the GSD community.

While often referred to as a ‘community’, GSD people are not a cohesive group.⁴² Within gender and sexual diversity is a diverse range of identities, bodies, and ways of being. For example; not every man who has sex with other men necessarily identifies as ‘gay’, but may have specific and unique

³⁷ Dewey JM. Knowledge legitimacy: how trans-patient behavior supports and challenges current medical knowledge. *Qual Health Res* 2008; 18 (10):1345–1355.

³⁸ James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The report of the 2015 U.S. transgender survey [Internet]. Washington, DC: National Center for Transgender Equality. [cited 2019 Jun 12]. Available from: <https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>.

³⁹ Waling A, Lim G, Dhalla S, Lyons A, Bourne A. *Understanding LGBTI+ Lives in Crisis*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, and Lifeline Australia; 2019.

⁴⁰ Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 18, 174 (2019). <https://doi.org/10.1186/s12939-019-1082-3>

⁴¹ Pennant ME, Baylis, SE, Meads, CA. Improving lesbian, gay and bisexual healthcare: a systematic review of qualitative literature from the UK. *Diversity & Equality in Health & Care*. 2009;6:193-203.

⁴² IBID [15].

needs and preferences regarding their health and social care.⁴³ Here, it is vital that health and social care is perceived and experienced as a safe and inclusive space for every Australian and that no one should feel that they may experience any form of prejudice or discrimination by accessing these services. The Religious Discrimination Bill would lead to a situation where spaces that should be safe for all Australians would be infused with the potential for experiencing offensive, uninformed, insulting, demeaning or damaging statements based in or about religion that would detrimentally impact on GSD people and pose a greater barrier to accessing and receiving safe, timely, and effective care. This is also likely to be further amplified by GSD people who also belong to other minority or marginalised groups including culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, people who have experienced homelessness or are homeless, and disabled people. Further, in order for GSD people to be able to expect health and wellbeing outcomes that are equal to other Australians, it must be ensured that their access and interfaces with the health and social care systems are equitable and attentive to the long history of fear, anxiety, and resulting avoidance and delays regarding care.

4) *Secondly, I was also really interested in the impact of this legislation on nurses working in schools. Could you give us some more information about the potential risks to nurses working in religious schools and the potential impacts on young people, particularly those that are same-sex attracted and gender diverse?*

Late childhood and adolescence are times when many people begin to explore their developing identity, gender, and sexuality. For many children and adolescents this is a time of confusion, loneliness, and turmoil. These experiences can be amplified amongst GSD children and adolescents particularly if they do not have supportive peers, adults, and communities around them.^{44,45} Australian school systems are often not set up to support GSD students, which results in unsafe and unsupportive environments and other institutional barriers to helping GSD students thrive. An important factor to students' feeling safe and supported in schools is their relationship with school nurses.⁴⁶ School victimization associated with lesbian, gay, bisexual, and transgender status experienced as an adolescent, is strongly associated with depression and life satisfaction. Schools that are 'safe spaces' for GSD students, such as those that have a Gay–Straight Alliance (GSA) or similar student groups are significantly associated with higher psychosocial well-being, educational attainment, and reduced high school dropout rates.⁴⁷ As a marginalised and commonly discriminated against group both in families and the community GSD youth are at a higher risk for poorer mental health, substance use, and other health concerns compared with their cisgender peers.^{48,49,50}

⁴³ Ong, J.J., M. Chen, S.N. Tabrizi, A. Cornall, S.M. Garland, F. Jin, et al., *Anal HPV detection in men who have sex with men living with HIV who report no recent anal sexual behaviours: baseline analysis of the Anal Cancer Examination (ACE) study*. *Sex Transm Infect*, 2016. **92**(5): p. 368-70.

⁴⁴ Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *Journal of child and adolescent psychiatric nursing*. 2010 Nov;23(4):205-13.

⁴⁵ Toomey RB, Ryan C, Diaz RM, Card NA, Russell ST. Gender-nonconforming lesbian, gay, bisexual, and transgender youth: school victimization and young adult psychosocial adjustment.

⁴⁶ Neiman T, Sieve L, Stenberg L, Molesky N, Nic Rider G. "Bridging the Gap": School Nurse Experiences Providing Care for Transgender and Gender Diverse Students and Their Parents/Guardians. *The Journal of School Nursing*. 2021 Jun 23:10598405211025442.

⁴⁷ Toomey, R. B., Ryan, C., Diaz, R. M., Russel, S. T. (2011). High school Gay-straight alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science*, 15(4), 175–185.

⁴⁸ Clark, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., Rossen, F. V. (2014). The health and well-being of transgender high school students: Results from the New Zealand adolescent health survey (Youth'12). *Journal of Adolescent Health*, 55(1), 93–99.

⁴⁹ Cotton, R. (2014). Supporting transgender students in schools. *British Journal of School Nursing*, 9(3), 141–143.

⁵⁰ Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., Eisenberg, M. E. (2018). Health and care utilization of transgender and gender non-conforming youth: A population-based study. *Pediatrics*, 141(3), e20171683.

Having a caring adult in the community or home and feeling safe at school are protective factors against experiencing emotional distress for GSD school students.⁵¹ GSD youth also report visiting school nurses more frequently than cisgender youth.⁵²

As detailed above, the Religious Discrimination Bill takes away existing anti-discrimination protections, including on the grounds of race, religion, sex, marital status, disability, sexual orientation, gender identity or intersex status. Australian school nurses and students will lose discrimination protections at work, school, and when accessing services like healthcare or supportive services to accommodate the religious beliefs of organisations or people who may make discriminatory statements against them. The Bill takes away rights from people who are currently protected under Australian anti-discrimination laws as faith-based institutions such as schools will maintain special exemptions allowing them to discriminate against school nurses, and students who rely on care and services provided by school nurses including sexual and mental healthcare and health promotion services. This is likely to be especially harmful to GSD students who may have additional barriers to healthcare access (as explained above) and particular needs regarding care and support that may not be shared by cis-gendered, heteronormative students.

The Religious Discrimination Bill would diminish GSD students' safety and comfortableness seeking care, support, and guidance from school nurses and would significantly impede school nurses' ability to provide care to this group of students. Further, GSD students may be less willing to access care and support school nurses if they feel that they may be discriminated against or likely to receive worse care due to the school organisation having religious/faith-based views or policies that oppose GSD identities. These impacts have the result of worsening the already poorer health and wellbeing outcomes and engagement of GSD people with necessary health services and further marginalising already at-risk, under-served members of the Australian school community.

⁵¹ Gower, A. L., Rider, G. N., Brown, C., McMorris, B. J., Coleman, E., Taliaferro, L. A., Eisenberg, M. E. (2018). Supporting transgender and gender diverse youth: Protection against emotional distress and substance use. *American Journal of Preventive Medicine*, 55(6), 787–794.

⁵² IBID [38].