



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

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Submission to the Productivity Commission's inquiry into the role of improving
mental health to support economic participation and enhancing productivity and
economic growth

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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. Through collaboration between communities, government, services, and researchers the Alliance provides a national focus to improve health outcomes for LGBTI people through policy, advocacy, representation, research evidence, and capacity building. The Alliance recognises that people's genders, bodies, relationships, and sexualities affect their health and wellbeing in every domain of their life.

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Executive Summary

The National LGBTI Health Alliance provides this submission to the Productivity Commission in its inquiry into the economic impacts of mental ill health. A key area of work for the Alliance is the improvement of mental health outcomes for LGBTI people and communities. This is through our Commonwealth funded programs:

- **QLife** an initiative of the Department of Health's Teleweb program, is directed by the Alliance in collaboration with Australia's state-based LGBTI counselling organisations which commenced in 2012, provides anonymous, LGBTI peer support and referral. QLife services are free and include both telephone and webchat support, delivered by trained LGBTI community members across the country.
- **MindOut** develops and delivers national suicide prevention initiatives aimed at building the capacity of the mental health and suicide prevention sectors to meet the support and wellbeing needs of LGBTI populations, thereby improving the mental health outcomes and reducing suicide and suicidal behaviour amongst LGBTI people and communities.
- **Silver Rainbow** provides national coordination and support activities promoting the well-being of LGBTI elders and the delivery of LGBTI awareness training to the aged care sector. Silver Rainbow works collaboratively with the government, aged care providers and related services, LGBT&I older people and elders and organisations to create an LGBT&I inclusive aged care sector.

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 a disproportionate number experience poorer mental health outcomes and have higher risk of suicidal behaviours than non-LGBTI people. 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. Consequently, LGBTI people and communities are a unique group in terms of risk factors for poor mental health and risk of suicide and who need responses in terms of mental health policy and programmes.

Whilst Australian and international research provide evidence that demonstrate the significant concern regarding the mental health outcomes and suicidal behaviours among LGBTI people, significant knowledge gaps remain. This is due to a lack of LGBTI indicators in national population research and data collection practices in mental health services and programmes and coroner report data. As quality and robust data informs evidence-based policy, this exclusion has led to inaccuracy in reporting and underestimates and has rendered LGBTI people relatively invisible in mental health and suicide prevention policies, strategies, and programmes. This cycle of invisibility compounds the poor mental health outcomes that LGBTI populations already experience.

The Alliance believes that fostering social inclusion where LGBTI people and communities are included in the fabric of Australian society through reducing discrimination, eliminating violence and removing legal barriers that affect their ability to experience connection will be essential in seeing improvements in not only their mental health, but also their general health and wellbeing. Good mental health among LGBTI people and communities will inevitably lead to an increase in their economic and workforce participation and enhance productivity and economic growth overall.

The Alliance recommends the following:

Recommendation 1

Inclusive and accessible care - LGBTI people experience equitable access to mental health and suicide prevention services and receive support that is appropriate to their experience and responsive to their needs.

Recommendation 2

Evidence, data collection and research - Establish an evidence base about LGBTI populations that adequately represents their histories, lives, experiences, identities, relationships and accurate recording of deaths by suicide.

Recommendation 3

Diversity of LGBTI population - The diversity within and between LGBTI populations be recognised and responded to with strategies and approaches that take into account their individual and unique needs.

Recommendation 4

Intersectionality and inclusion - LGBTI people from across all populations, backgrounds and circumstances experience an increase in social inclusion and a reduction in stigma and discrimination.

Recommendation 5

Skilled and knowledgeable workforce - The mental health and suicide prevention sector workforce be knowledgeable regarding LGBTI people, and skilled, confident, and competent in responding to their support needs.

Recommendation 6

Promotion and prevention - Mental health promotion and suicide prevention programs, activities and campaigns address the underlying factors that compound the mental health outcomes for LGBTI populations and work to eradicate the causal factors for minority stress.

Recommendation 7

National Strategy – Federal government commit to the creation, implementation and evaluation of a National LGBTI Health and Inclusion Strategy that focuses on mental health and suicide prevention.

Mental Health Experiences of LGBTI People

Despite recent legislative reforms and advances in the human rights of LGBTI people, parallel improvements in their health and wellbeing are not being realised. The large health disparities that exist between LGBTI people and the general community have been widely attributed to the impact of stigmatising sexuality, gender and bodily diversity. The Minority Stress model postulates that individuals from socially stigmatised population groups are exposed to unique chronic stressors.¹ For LGBTI people this includes experiences of discrimination, harassment and physical violence. These experiences of stigma, in turn, create a stressful social environment, which is a risk factor for poor mental health.²

A core function of heteronormative³ and cisnormative⁴ culture is to position people who are sexuality and gender diverse as a minority group and render them invisible, consequently reinforcing and sustaining heteronormativity and cisnormativity as systems of privilege. It is important to note that heteronormative assumptions also inform the forced and coercive medical interventions conducted on intersex infants and children in clinical settings. Key clinician documents cite “gender identity confusion” and ideas about heteronormative sexual function as rationales for conducting these interventions. The idea that a child will grow up to be non-heterosexual or not identify with a surgically or hormonally-reinforced sex is not adequately considered within medical discourse.⁵

It is crucial to recognise the social determinants of health, which highlight the overlapping and interdependent systems that negatively affect the health and wellbeing of LGBTI populations in Australia. Therefore, much of the work to ameliorate the negative social and structural factors influencing their health will lie beyond the realms of the health system⁶.

¹ Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>

² Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health*, 100, 452–459. <https://doi.org/10.2105/AJPH.2009.168815>; Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, 135, 531–554. <https://doi.org/10.1037/a0016059>; Perales, F., & Todd, A. (2018). 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*, 208, 190–199. <https://doi.org/10.1016/j.socscimed.2018.05.015>

³ Heteronormativity is the dominant and pervasive belief that heterosexuality is the normal or legitimate form of sexuality.

⁴ Cisnormativity is a term that describes the privileging of cisgender identities (gender identity that aligns with an individual's sex assigned at birth).

⁵ IHRA. (2018). ‘Submission to the Australian Human Rights Commission: Protecting the Human Rights of People Born with Variations in Sex Characteristics’. <https://ihra.org.au/32490/ahrc-submission-2018/>

⁶ Leonard, W. & Metcalf, A. (2014). Going Upstream: A Framework for Promoting the mental health of LGBTI people Sydney. National LGBTI Health Alliance. Available from: <https://www.lgbtihealth.org.au/sites/default/files/going-upstream-online-o-lgbti-mental-health-promotion-framework.pdf>

Below is a snapshot of what is known of the current mental health and wellbeing outcomes of LGBTI people in Australia.

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.⁷

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.⁸

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 distress⁹, 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.¹⁰

⁷ 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.

⁸ 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

⁹ Hyde et al. (2014)

¹⁰ 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

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 abuse¹¹. 61% of same-gender attracted and gender diverse young people have experienced verbal abuse, and 18% physical abuse.¹²

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.¹³

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).¹⁴

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 heterosexual¹⁵.

¹¹ 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>

¹² 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

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

¹⁵ Leonard W, Lyons A & 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

Inclusive and Accessible Care

Receiving welcoming, equitable and inclusive care without encountering barriers to accessing support on the basis of their sexuality, gender, or variations in sex characteristics, is crucial for addressing the mental health needs of LGBTI people.

Religious exemptions endorsed by legislation frequently act as discriminative barriers to LGBTI individuals and should never exclude a person from getting the help they need. Exemptions for religious-based organisations that deliver Commonwealth funded mental health and suicide prevention programs under the *Sex Discrimination Act 1984* must be removed. Mental health and suicide prevention programmes and services must also be resourced and supported to proactively and strategically increase their accessibility to LGBTI people and communities. Additionally, it is vital to develop and resource mental health and suicide prevention initiatives that specifically target LGBTI populations, and where available be implemented and delivered by LGBTI peer-based organisations or agencies that have a core mission of providing programmes and services to LGBTI people and communities. Recognition and specific inclusion of LGBTI populations in the development of any national standards for the mental health and suicide prevention services is also paramount.

It is important to note that structural barriers can exist in many different parts of the care framework for LGBTI people, beyond seeking mental health services. This includes in housing services, employment services, legal services and a host of others. Anyone working with the Australian public at large has a responsibility to make their service as open and accessible as possible to people of all backgrounds, including LGBTI individuals and populations.

Recommendation 1

Inclusive and accessible care - LGBTI people experience equitable access to mental health and suicide prevention services and receive support that is appropriate to their experience and responsive to their needs.

Evidence, Data Collection and Research

According to the 2016 Census, people in same-sex couples tend to be more highly educated than people in opposite-sex couples. The ABS found that 45% of people in same-sex couples had a Bachelor degree or higher qualification, compared with 29% of people in opposite-sex couples. Also, people in same-sex couples were also more likely to have a postgraduate degree than people in opposite-sex couples (12.4% compared with 6.8%).

Same-sex couples were more likely to participate in the labour force and be employed, than opposite-sex couples and were more likely to have higher personal incomes than those in opposite-sex couple relationships.¹⁶

It is important that research findings such as these that portray same-sex couples as being privileged by way of education, employment and income are well understood. While it can be gleaned that same-sex couples are productive and contribute significantly to support economic participation and enhancing productivity and economic growth, there does need to be an understanding about the reality of many individual life experiences and the burden that comes with the territory of being from LGBTI communities. Therefore, robust and fully encompassing research should be undertaken.

While Australian and international research provide evidence that demonstrate significant concern regarding mental health outcomes and suicidal behaviours among LGBTI people, it is vital to note that significant knowledge gaps remain. This is due to lack of inclusion of sexual orientation, gender identity and intersex status in population research and data collection in mental health services. As data informs evidence-based policy, this exclusion has led to inaccuracy in reporting and significant underestimates that has left LGBTI people relatively invisible in mental health and suicide prevention policies, strategies and programmes.

Consequently, Australian national evidence on the health and wellbeing of LGBTI populations relies upon a growing but limited number of smaller scale studies that target LGBTI populations, or part thereof. While uniquely valuable, these can have methodological issues relating to representative data collection and limited ability to provide a comprehensive data analysis that is therefore unable to represent a holistic picture of LGBTI people.

Some mental health service providers commonly imply or state that they do not have any LGBTI clients. However, that is often not the case; instead, a cycle of ignorance and invisibility is in place. Without explicit inclusive policies, structures and practices, LGBTI people can feel fearful when accessing mental health services. In an attempt to protect themselves, many LGBTI people will then hide or modify their identities, bodies, experiences, relationships and/or attractions, rendering themselves invisible. This can lead service providers to assume they don't have any LGBTI clients or patients and, therefore, that they do not need to consider their needs in service provision, planning and practices. At a higher policy level there is very little to no data on LGBTI populations, so there is limited evidence to support the need for services. Consequently, LGBTI populations are often excluded from policy creation, program implementation and evaluation.

¹⁶ Australian Bureau of Statistics, 2018, *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016*, cat. No. 2071.0
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Same-Sex%20Couples~85>

Increasing an informed evidence base and knowledge about LGBTI populations will contribute to improving the mental health and economic participation and productivity of LGBTI people and communities. This can be facilitated by the following measures:

- Establishing a national minimum data set that includes demographic information about sexuality, gender identity and variations in sex characteristics is crucial in facilitating an understanding of LGBTI people behaviours, experiences and identities within mental health and suicide prevention services
- Include LGBTI identifiers suicide registers and standardised reporting on suicide to include LGBTI identifiers and population indicators
- The Australian Bureau of Statistics to appropriately collect data on the sexual orientation, gender identity and variations in sex characteristics of the Australian population in the national Census
- Review the Australian Government Guidelines on the Recognition of Sex and Gender across departments and agencies in consultation with trans, gender diverse and intersex people
- Creating a well-coordinated and funded national program of LGBTI health research that secures poorly funded yet highly valuable existing research studies as well as new studies that are community and sector developed is needed. This research should then be applied to policy and practice as they relate to LGBTI mental health and suicide prevention

Recommendation 2

Evidence, data collection and research – Increase the evidence base and knowledge about LGBTI populations that adequately represents their histories, lives, experiences, identities, relationships and accurate recording of deaths by suicide.

Diversity of LGBTI Population

‘LGBTI’ is often viewed as a single category about which can be spoken about in broad generalisations. However, within ‘LGBTI’ there are several distinct, but sometimes overlapping, demographics each with their own distinct histories, experiences and health needs. It is important that the diversity within and between LGBTI populations be recognised by mental health and suicide prevention programmes, services, research and evaluation and responded to with strategies that into account their individual and unique needs. Furthermore, they must also recognise that some groups within LGBTI populations are at higher risk of psychological distress than others according to gender identity, sexual identity, age and socio-economic status, and develop targeted responses accordingly.

Individual experiences should be recognised as fundamental to appropriate care. This involves the implementation of person-centred approach initiatives that acknowledge and respond to the specific and individual needs of people and communities within LGBTI populations. Additionally, recognising that different approaches will be required for different individuals and population groups including bisexual people, trans and gender diverse people and intersex people is crucial. Mental health and

social services that approach the needs of LGBTI people by having policy or practices of ‘treating everyone the same’ are deficient in their ability to meet their overall mental health needs.

Recommendation 3

Diversity of LGBTI population - The diversity within and between LGBTI populations be recognised and responded to with strategies and approaches that take into account their individual and unique needs.

Intersectionality and Social Inclusion

Many LGBTI people experience multiple, interconnected and reoccurring forms of harm related directly to their sexuality, gender identity and/or their sex characteristics¹⁷. Consideration should be given to other identity-driven needs and roles LGBTI people may have. Person-centred approach initiatives should be developed, which acknowledge and respond to the specific and individual needs of LGBTI people and communities who belong to multiple marginal identities, with the recognition that different approaches will be required for different individuals and population groups 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.

Discrimination and exclusion are the key causal factors of mental-ill health and suicidality for LGBTI people. Addressing societal prejudice is arguably the best prevention measure for LGBTI person suicide and self-harm that can be achieved. Discrimination against LGBTI people can take both obvious and subtle forms. It is common that LGBTI people negotiate stigma on an almost daily basis, including structural exclusion that limits full access to social participation and which is embedded in legislation, policy and practice. A ‘treating everyone the same’ framework response to discrimination only shifts the burden to individuals to make sure their own needs are met, which is often too great a burden for vulnerable individuals. If there is any possibility of a hostile response from a service provider, LGBTI people are less likely to engage in help seeking behaviours. An adequate response to exclusion requires services to be explicitly inclusive of LGBTI people, without expecting LGBTI people themselves to solve systemic barriers to accessing culturally appropriate care.

Recommendation 4

Adopting an intersectionality approach and fostering social inclusion - LGBTI people from across all populations, backgrounds and circumstances experience an increase in social inclusion and a reduction in stigma and discrimination.

¹⁷ International Commission of Jurists, (2007). Yogyakarta Principles plus 10: Principles on the application of international human rights law in relation to sexual orientation and gender identity. Available from http://yogyakartaprinciples.org/wp-content/uploads/2017/11/A5_yogyakartaWEB-2.pdf

Skilled and Knowledgeable Workforce

Poor mental health outcomes for LGBTI people are compounded by being turned away from a service because of the lack of knowledge, skills and confidence from service providers including those who actively refuse to engage with potential LGBTI clients. There are several measures that can be implemented to respond to this issue. Firstly, LGBTI populations should be involved in the development of any national practice standards for the mental health and suicide prevention workforces. Secondly, resourcing and support for the implementation of standards in the *National Practice Standards for the Mental Health Workforce* that relate to LGBTI populations. Thirdly, professional development resources that support the implementation of these standards must be reviewed and updated to ensure adequate and accurate inclusion of LGBTI populations. And finally, promoting awareness and understanding across the mental health and suicide prevention sectors about the *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 (Cth)*.

The Alliance also calls for further investment in the National LGBTI Health Alliance to lead on national coordination and implementation of education, training and professional development on LGBTI populations within the mental health and suicide prevention workforce.

Recommendation 5

Skilled and knowledgeable workforce - The mental health and suicide prevention sector workforce be knowledgeable regarding LGBTI people, and skilled, confident, and competent in responding to their support needs.

Promotion and Prevention

Key measures that will assist with addressing the underlying factors that compound the mental health outcomes of LGBTI populations include:

- Recognition and specific inclusion of LGBTI populations as priority populations in the development of any mental health and suicide prevention strategies, frameworks, programmes and services
- Development of mental health and suicide prevention health promotion and prevention campaigns, resources, programmes and services that target and focus on LGBTI people and communities utilising *Going Upstream: LGBTI Mental Health Promotion Framework*
- Support and resourcing for the establishment, development and growth of LGBTI peer led programmes, services organisations and groups supporting LGBTI people and communities
- Community capacity building initiatives to be developed and implemented with LGBTI people and communities, to increase their capacity to identify and respond to mental health needs of people in their communities
- Development, implementation and integration of LGBTI mental health and suicide prevention strategies across sectors including health, HIV, housing, employment, education

and training, justice, drug and alcohol, domestic and family violence and social and community engagement

- Legislative and policy reform to ensure freedom from all forms of discrimination on the basis of sexual orientation, gender identity and intersex status, specifying violence, harassment and the provision of goods and services.

Recommendation 6

Promotion and prevention - Mental health promotion and suicide prevention programs, activities and campaigns address the underlying factors that compound the mental health outcomes for LGBTI populations.

Conclusion

The Alliance believes that a strategic and coordinated approach, which considers meaningful change at the legislative, community and social level is needed to address the health disparities that exist between LGTBI populations and the general community. This will require an effort across multiple sectors beyond health, including education, employment, social services, housing and justice. A paradigm shift that decentres heteronormativity and embraces sexuality, gender and bodily diversity, coupled with the collection of quality and robust data and evidence will help increase social inclusion and reduce stigma and discrimination in the lives of LGBTI people. These measures will result in a more supporting and accepting societal environment that will act as a protective factor for the mental health and wellbeing of LGBTI people, and lead to an increase in Australia's economic and workforce participation and enhance productivity and economic growth.