Submission to the Productivity Commission:

Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth

5 April 2019

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest community-controlled health service providers for people living with HIV and the lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) communities. Its services include general practice, health promotion, counselling, family violence, housing support, and alcohol and other drug rehabilitation and harm reduction programs. Thorne Harbour Health primarily serves the populations of Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTI people and all people living with HIV.

Rainbow Health Victoria

Rainbow Health Victoria are a team within the Australian Research Centre in Sex, Health and Society at La Trobe University. We are funded by the Victorian government to promote the health and wellbeing of LGBTI Victorians. We work to produce high quality research, knowledge translation, evidence-based training, resources and policy advice. We build partnerships with government, researchers, community organisations and service providers to create equity and inclusion.

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1. Introduction

Thorne Harbour Health and Rainbow Health Victoria welcome the Productivity Commission's inquiry into the role of improving mental health to support economic participation and enhance productivity and economic growth. We have also seen and endorse the Public Health Association of Australia's submission.

Research shows that lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTI) Australians experience poorer mental health outcomes than the general population. Stigma, prejudice, discrimination and abuse on the basis of LGBTI status can adversely affect the employment, social participation, mental health and wellbeing of members of LGBTI communities, and contribute to the broader health disparities they experience.

The mental health burdens experienced by LGBTI Australians must be prioritised to improve health outcomes and participation in social and economic life. Up to 11% of the Australian population may have a diverse sexual orientation, sex or gender identity.[1] Work-related productivity loss results in substantial economic losses for employees, organisations, and society. High levels of mental ill-health among LGBTI populations limits their full and positive participation in economic life, and reduces benefits associated with diversity in the workforce.

2. Summary of recommendations

1. Endorse the proven mixed model of mental health service provision that includes both mainstream and community-controlled LGBTI and HIV mental health and wraparound support services, and which gives priority to community-controlled services.
2. Endorse community-controlled vocational service providers that are capable of assisting LGBTI people and people living with HIV assess employment-related risks, facilitate pathways and skill development, and address underlying barriers to employment through integrated service-provision.
3. Estimate the economic benefit of inclusive and diverse workplaces and their impact on the mental health of employees, including the mental health of minority groups such as LGBTI communities, people living with HIV, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander communities.
4. Include LGBTI people as a priority population in all health policy responses.
5. Increase sustained, ongoing funding for community-controlled LGBTI mental health and wraparound support services to enhance capacity to meet demand and expand their geographical reach.
6. Increase funding for LGBTI training of mainstream mental health services, and consider making such training a requirement of relevant accreditation bodies, and/or encourage organisations to undertake Rainbow Tick accreditation.
7. Co-design and build in an understanding of intersectionality and minority stress to any proposed alternative mental health and other health and support services.

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[1] Australian Human Rights Commission, 'Face the Facts: Lesbian, Gay, Bisexual, Trans and Intersex People' (2014).

3. Background and consequences of mental ill-health

3.1. LGBTI people have higher rates of mental illness

The available evidence shows that LGBTI communities have much higher rates of depression, anxiety, substance abuse, self-harm, suicidal ideation and suicide compared to the general population.[2] It is important to note that there are differences within the broad category of 'LGBTI', with young, bisexual, and trans and gender diverse people among those particularly at risk. The reasons for higher rates or poor mental health and suicidality among LGBTI people are not always clear. However, the literature shows that there are associations between poor mental health and experiences of disconnection from family or communities, or discrimination and harassment.

Mental ill-health has direct economic costs related to health care, disability payments, and the provision of support services. Indirect costs include the burdens imposed on care-givers, family members and communities of people living with mental illness. Health policy must be responsive to the health needs of LGBTI populations, which are shaped by distinct social determinants, histories, and experiences, and adequate funding must be provided and measures taken to rectify the significant mental health burden experienced by LGBTI people.

3.2. Stigma and discrimination are a barrier to service use

Due to ongoing perceptions and experiences of stigma and discrimination, access to mainstream mental health and other health and support services represents a significant structural barrier to adequate care and treatment for LGBTI people. Indeed, nearly 34% of LGBT Australians report "usually or occasionally" hiding their sexual orientation or gender identity when accessing services.[3]

Despite a legal and social environment that is increasingly supportive of LGBT people, harassment and discrimination driven by homophobia and transphobia still occurs. Moreover, to a great extent people born with variations in sex characteristics (intersex variations) are still pathologised, with perfectly healthy intersex children subjected to medically unnecessary interventions including hormone injections and sex-reassignment surgery, which results in physical and psychological harm,[4] and fosters mistrust of the medical profession[5] that presents a barrier to intersex people accessing health care.

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[2] LGBTI National Health Alliance, 'Snapshot of mental health and suicide prevention statistics for LGBTI people' (2016) <https://lgbtihealth.org.au/wp-content/uploads/2016/07/SNAPSHOT-Mental-Health-and-Suicide-Prevention-Outcomes-for-LGBTI-people-and-communities.pdf>

[3] William Leonard et al, 'Private Lives 2: The second national survey of the health and wellbeing of GLBT Australians' (Monograph Series Number 86, 2012) Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne VIII <https://www.glhv.org.au/sites/default/files/PrivateLives2Report.pdf>

[4] Sarah M Creighton, 'Long-term outcome of feminization surgery: the London experience' (2012) 93(3) *British Journal of Urology International* 44-46; Jaqueline Hewitt and Margaret Zacharin, 'Hormone replacement in disorders of sex development: current thinking' (2015) 29(3) *Best Practice & Research Clinical Endocrinology & Metabolism* 437-447.

[5] Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or coerced sterilisation of intersex people in Australia* (2013) 31 [2.36]

Although significant knowledge gaps remain, available data about the mental health of LGBTI populations highlights the consequences that poorer mental health outcomes can have on productivity and participation.

3.3. Young LGBT people are most at risk of poor mental health

Typically, the onset of mental illness occurs in mid to late adolescence, with Australian youth aged 18–24 having the highest prevalence of mental illness than any other age group.[6] Some studies have reported high levels of homophobic bullying at schools, with 80% of participants naming school as a place where bullying occurs.[7] Health outcomes are worsened by delayed treatment, and the provision of socially and culturally appropriate treatment during the crucial development periods of childhood, adolescence and young adulthood provides both immediate and long-term positive outcomes.[8]

Consistent with broader epidemiological research, the burden of mental ill-health in LGBT[9] people appears to decrease slightly across the lifespan, with age generally having a positive mediating effect on wellbeing; however, outcomes remain poor when compared to the general population. A national study of LGBTI health and wellbeing, *Private Lives*, found that the rates of psychological distress were highest amongst 16–24 year olds, with psychological distress and mental health diagnosis tending to decline in the age groups of 25–44 and 45–59, with the 60–89 year old age grouping faring the best.[10] The LGBT working-age population, generally defined as those aged 15–64, is therefore marked by a higher burden of poor mental health. This has significant flow-on effects for productivity and social participation.

Young LGBTI people still have their whole lives ahead of them, and so the greatest economic impact can be found in addressing mental health disparities early on for this high-risk population, through adequately resourced and appropriate linkage to preventative, primary and wraparound support and care.

3.4. Mixed rates of workforce participation

Current census data indicates that same-sex couples have higher rates of education, labour force participation, and income compared with opposite-sex couples.[11] While there is an underreporting of same-sex couples, in 45% of reported same-sex couples, both partners were

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[6] L Ivancic et al, 'Youth Mental Health Report' (June 2014) Mission Australia and Black Dog Institute, Sydney.
[7] Lynne Hillier, et al (2010). 'Writing Themselves In 3' Australian Research Centre in Sex, Health and Society, La Trobe University.
[8] Department of Health and Ageing, Commonwealth of Australia, 'National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011' (2013), Canberra, 83.
[9] There is a lack of long-term mental health data in relation to intersex people.
[10] Department of Health and Ageing (2013) op. cit. 8.
[11] Australian Bureau of Statistics, 'Same-sex couples in Australia' (18 January 2018, last updated 11 July 2018) <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Same-Sex%20Couples~85>

working full-time compared to 22% of opposite-sex couples; this is because, on average, same-sex couples are younger and have fewer children.[12] Despite the demonstrated positive emotional health effects of full labour participation,[13] the mental health burden in this cohort remains high.

Internalising problems, experiences of mental distress, and associated stressors can contribute to a lack of job satisfaction and other measures of workplace productivity loss, such as presenteeism and absenteeism.[14] This is concerning, because research conducted by the Australian Centre in Sex, Health, and Society indicates that 39% of young LGBTI people aged 16–24 conceal their sexuality or gender identity at work,[15] and research conducted by the Diversity Council of Australia found that LGBTI workers who do so are twice as likely to feel down at work as those who are out, and 45% less likely to be satisfied with their job.[16] LGBTI employees who are out to everyone at work are also 50% more likely to innovate, 35% more likely to work highly effectively in their team, and 28% more likely to provide excellent customer/client service.[17]

While further research is need, available evidence indicates that internalised stigma, fear of discrimination, and high rates of mental distress amongst LGTBI people is likely leading to lower rates of job satisfaction and higher rates of presenteeism and absenteeism.

Furthermore, a recent survey of 540 trans and gender diverse people found that 53% had a university degree or higher, but 21% were unemployed.[18] A high prevalence of psychiatric conditions in this population was found, with depression diagnosed in 55.7% and anxiety in 40.4% of participants.[19] The low rates of workplace participation in trans and gender diverse people has considerable economic and social costs not only for society, but individuals themselves, whose continued exclusion from social and work life further negatively affects their mental health, compounds housing stress, and long-term capacity to enter or participate in an increasingly competitive labour market structure.

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[12] Australian Bureau of Statistics (2018) op. cit. 12.
[13] Royal Australasian College of Physicians, 'Realising the health benefits of work – an evidence update' (November 2015) <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-health-benefits-of-work-evidence-update.pdf?sfvrsn=af75331a_6>
[14] Melisa Bubonya, Deborah Cobb-Clark, and Mark Wooden, 'Mental health and productivity at work: Does what you do matter?' (No 2016-06, November 2016) Life Course Centre, ARC Centre of Excellence for Children and Families over the Life Course, Institute of Social Research, The University of Queensland <https://www.lifecoursecentre.org.au/wp-content/uploads/2018/06/2016-06-LCC-Working-Paper-Bubonya-et-al..pdf>
[15] Leonard et al (2012) op. cit. 3. p.VIII
[16] Diversity Council of Australia, 'Out At Work: From Pride to Prejudice' (Infographic, date unknown) <https://www.dca.org.au/research/project/out-work-prejudice-pride>
[17] Ibid.
[18] Ada S Cheung et al, 'Sociodemographic and clinical characteristics of Transgender Adults in Australia' (2018) 3(1) *Transgender Health* 229-238.
[19] Ibid.

3.5. Mental health and people living with HIV

People living with HIV face pervasive cultural stigma that can create barriers to workforce participation. Although HIV status is not associated with additional productivity losses in working people (compared to other health issues), people living with HIV are less likely to be employed due to complex stigma-related barriers, emotional factors, and disclosure-related stress related to the workplace.[20] Psychological distress in people living with HIV has been cited as a factor that precipitates their leaving the workforce or not participating at all.[21]

Furthermore, people living with HIV who also have a serious mental illness are less likely to adhere to antiretroviral medication.[22] This impacts their ability to enter the workforce and engage in sustained work; being asymptomatic or having an undetectable viral load are positively associated with successful labour force participation, and a strong sense of personal identity can also have facilitative effects for employment.[23]

4. Effectiveness and cost of current programs and support

4.1. Community-controlled health services are highly effective and cost-effective

Community-controlled[24] health services such as Thorne Harbour Health have a history of mobilising community-led responses to health issues that are capable of overcoming access barriers posed by privacy concerns, stigma and discrimination experienced by LGBTI populations.[25] Supportive care environments facilitate people seeking the care they need and ultimately this results in better health outcomes.

Community-controlled organisations have had a significant effect on improving the health and wellbeing of LGBTI communities. In Victoria, Thorne Harbour Health's mental health services currently include: general and AOD-specific counselling; therapeutic groups on homophobia, methamphetamine use and anxiety; and a website for same-sex attracted men in heterosexual relationships.

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[20] Kaya Verbooy et al, 'Are people living with HIV less productive at work?' (2018) 30(10) *AIDS Care* 1265-1272.
[21] Catherine Worthington, et al, 'Enhancing Labour Force Participation for People Living with HIV: A Multi-Perspective Summary of the Research Evidence' (2012) 16(1) *AIDS and Behavior* 234.
[22] Jeffrey S Gonzalez et al, 'Depression and HIV treatment nonadherence' (2011) *Journal of Acquired Immune Deficiency Syndromes*, online edition. DOI:10.1097/QAI.0bo13e31822d490a
[23] Worthington et al (2012) op. cit. 22 pp. 234-245.
[24] Community-controlled services are run by and for members of a community. They allow communities to have control over issues that directly affect those communities.
[25] Nous Group, 'Demonstrating the value of community control in Australia's HIV response: AFAO and Australia's State and Territory AIDS Councils' (24 June 2016).

4.2. Case study – Housing Plus as a cost-effective, best practice example of a targeted support service for people living with HIV

Housing Plus is a state-wide Victorian program operated by Thorne Harbour Health that supports people living with HIV who are homeless or at risk of homelessness to seek appropriate and stable accommodation.

We know from the social determinants model of health that people's mental health depends on their basic needs such as housing being met; a fact emphasised by the story of James May, a Housing Plus client who shifted from rooming houses to transitional housing:

> *It was the first time I'd had my own space since contracting HIV and I was astounded by the difference it made… I didn't have to hide my sexuality or my HIV status from anyone… I had the space and privacy to focus my energy on the physical and emotional challenges of living with the virus and adjusting to ART therapy.*
>
> *For the first time I could stock the fridge and pay close attention to my nutrition… I could sleep soundly at night without the chaos of people coming and going in a rooming house. My health soared and it made me realise how essential a safe, comfortable home is – particularly when you're living with HIV.[26]*

Housing Plus streamlines client referrals to Thorne Harbour Health's mental health and other health and support services, which provides efficiencies and data integration between services. This emphasises the importance, and is a best practice example of, community-controlled health service delivery and integration of mental health and wraparound support services.

Recommendation 1
Endorse the proven mixed model of mental health service provision that includes both mainstream and community-controlled LGBTI and HIV mental health and wraparound support services, and which gives priority to community-controlled services.

Recommendation 2
Endorse community-controlled vocational service providers that are capable of assisting LGBTI people and people living with HIV assess employment-related risks, facilitate pathways and skill development, and address underlying barriers to employment through integrated service-provision.

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[26] James May, 'AHAG: Still providing housing, support and referral' (June 2011) 57 *Poslink* 14-15. <https://livingpositivevictoria.org.au/wp-content/uploads/2016/12/Poslink_Issue_057.pdf>

5. Gaps in current programs and supports available

The significance of community-controlled organisations is reflected in the intent of the National Mental Health Policy regarding consumer and carer participation—that is, 'Nothing about us, without us'.[27] Despite this and other welcome developments, LGBTI people are historically missing in Government policy, strategy, funding and data collection, and we note there is no mention of LGBTI communities in the Productivity Commission Issues Paper.

5.1. Recognise LGBTI as a priority population and fund accordingly

The emerging recognition of LGBTI communities as a priority population in health policy responses stands in contrast to their continued absence in most funded program data collections, including mental health programs.

While LGBTI people are beginning to be recognised as a priority population with distinct health needs, this recognition must be supported by improved data collection, training, and increased funding to improve mental health and other health and wraparound support services. Currently, many mainstream health services fail to adequately or appropriately collect LGBTI data or train their staff in culturally appropriate LGBTI care, and community-controlled LGBTI health services are unable to meet demand due to their limited capacity and geographical distribution.

Recommendation 3
Estimate the economic benefit of inclusive and diverse workplaces and their impact on the mental health of employees, including the mental health of minority groups such as LGBTI communities, people living with HIV, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander communities.

Recommendation 4
Include LGBTI people as a priority population in all health policy responses.

Recommendation 5
Increase sustained, ongoing funding for community-controlled LGBTI mental health and wraparound support services to enhance capacity to meet demand and expand their geographical reach.

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[27] National Mental Health Commission, 'Fifth National Mental Health and Suicide Prevention Plan' (October 2017) 4. <https://www.mentalhealthcommission.gov.au/our-reports/fifth-national-mental-health-and-suicide-prevention-plan.aspx>

5.2. LGBTI training needed for mainstream mental health services

Training programs in LGBTI inclusion are important for increasing staff knowledge and skills, they cannot ensure safe and inclusive workplaces. This requires training to be embedded in a comprehensive strategy for systemic culture and workplace system change. A number of inclusive practice audit tools and self-assessment tools are available, along with resources and guides to assist organisations in undergoing this change.

The Rainbow Tick program is a quality framework that helps organisations demonstrate that they are safe, inclusive and affirming services and employers for LGBTI communities. It is made up of six standards designed to build lasting LGBTI cultural safety. The Rainbow Tick is a world first and was developed by Rainbow Health Victoria in consultation with Quality Innovation Performance (QIP), the organisation that conducts the accreditation process.

> **Recommendation 6**
> Increase funding for LGBTI training of mainstream mental health services, and consider making such training a requirement of relevant accreditation bodies, and/or encourage organisations to undertake Rainbow Tick accreditation.

6. Likely effectiveness of alternative programs and supports

In its 2017 Plan, the National Mental Health Commission recognised LGBTI people as one of a number of groups with relatively high needs, and stated that "reducing stigma and improving the appropriateness of mental health services is critical for LGBTI communities".[28] The Victorian Government's *Victorian suicide prevention framework 2016–2025* also identified LGBTI people as one of a number of vulnerable groups needing support.[29]

6.1. Effective programs must understand intersectionality and minority stress

The recognition of age, class, gender, race, sexuality, cultural background and disability offers a framework for inclusive consideration of multiple risks and disadvantage. People who are LGBTI and from an Aboriginal and Torres Strait Islander or culturally and linguistically diverse background, or who have a disability can face multiple, compounding risks and disadvantages,

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[28] National Mental Health Commission (October 2017) op. cit. 28 p.6.
[29] Department of Health and Human Services (Vic), 'Victorian Suicide Prevention Framework 2016-2025' (July 2016) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-suicide-prevention-framework-2016-2025>

and the effectiveness of programs and supports depends on this being recognised and addressed in policy and service design and delivery.

Another important consideration is how minority stress - the stress caused by stigma and discrimination - impacts on the rate and severity of mental health conditions amongst members of LGBTI communities, people living with HIV, people from culturally and linguistically diverse backgrounds, people with disabilities, and other minority populations.

In disaggregating LGBTI communities in data collection it is essential to understand that there are several distinct but sometimes overlapping demographics, each with their own distinct histories, experiences and health needs.[30]

Recommendation 7

Co-design and build in an understanding of intersectionality and minority stress to any proposed alternative mental health and other health and support services.

6.2. Case study – best practice service delivery for trans and gender diverse people

Equinox is a trans and gender diverse health service operated by Thorne Harbour Health. Its practices are community-informed and services work together with the community to provide safe and inclusive spaces for trans and gender diverse people. Equinox links community-controlled clinical care with mental health and wraparound support, streamlining referrals and providing better continuity of care. Continuity of care improves care and results in better, more cost effective treatment outcomes.

Other recent initiatives that are examples of best practice in relation to trans and gender diverse health care and research include:
- *Trans and Gender Diverse Health, Churchill Recommendations, March 2019* [31]
- *Policy and Practice Recommendations for Alcohol and Other Drugs (AOD) Service Providers Supporting the Trans and Gender Diverse (TGD) Community* [32]
- Research projects that engage trans and gender diverse communities in a respectful and culturally appropriate way, such as recent research by Dr Ada Cheung, Austin Health, University of Melbourne, which provides much-needed data into the clinical and sociodemographic characteristics of transgender adults in Australia.[33]

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[30] LGBTI National Health Alliance (2016) op. cit. 2.
[31] Jeremy Wiggins et al, 'Trans and Gender Diverse Health Churchill Recommendations' (March 2019) LGBTQ Education and Advocacy Project, Churchill Trust.
[32] Thorne Harbour Health (formerly the Victorian AIDS Council) and the Victorian Alcohol and Drug Association, 'Policy and Practice Recommendations for Alcohol and Other Drugs (AOD) Service Providers Supporting the Trans and Gender Diverse (TGD) Community' (2017).
[33] Ada S Cheung et al (2018) op. cit. 18.

7. Conclusion

LGBTI people experience significantly poorer mental health than the general population, and until fairly recently have been omitted from health policy responses, which has resulted in significant gaps in LGBTI data collection and targeted service provision.

Community-controlled LGBTI health services are highly effective at engaging LGBTI communities, improving their access to health care, and contributing to better health outcomes. By comparison, mainstream health services often present considerable access barriers to LGBTI people due to actual or perceived experiences of stigma and discrimination.

There are gaps in safe, culturally appropriate mental health service provision for people from LGBTI communities, with many mainstream services lacking adequate training in relation to the provision of safe and culturally appropriate care for LGBTI people.

Many LGBTI community-controlled health services are currently unable to meet demand due to a lack of sustained, ongoing funding, despite experiencing a sustained, ongoing demand for services. A lack of funding has also resulted in the centralisation of LGBTI health and wraparound support services, limiting access for people from rural and regional areas.

Only by recognising LGBTI people as a priority population in health policy responses, and adequately funding community-controlled LGBTI mental health and wraparound support services, will we begin to close the mental health gap that exists between LGBTI people and the general population, and promote greater economic and social participation by people from these communities.