Mental Health Australia

Advice to the National Mental Health Commission:

National Stigma and Discrimination Reduction Strategy

November 2021

Mentally healthy people,
mentally healthy communities

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Contents

Introduction

Mental Health Australia is working with its members to contribute to addressing stigma and discrimination associated with mental illness. This paper has been developed in consultation with our members via a Members Policy Hub process to inform the National Mental Health Commission's (NMHC) development of the National Stigma and Discrimination Reduction Strategy ('the Strategy').

Focus on structural stigma and discrimination

"'Stigma' refers to negative attitudes that lead to the exclusion of others on the basis of a particular characteristic."[1] It can take several forms including self-stigma (where people are socialised into believing they are devalued), social stigma (where community members judge certain traits to be contrary to community norms) and structural stigma (where rules, policies and practices of institutions restrict opportunities).[2] Discrimination on the other hand is "the behaviour people experience as a result of these [stigmatising] attitudes."[3]

The NMHC has advised Mental Health Australia members of its intention to focus on structural stigma and discrimination in the Strategy. This provides an opportunity to inform systemic legislative, policy, programmatic, cultural and organisational change aimed at addressing the impacts of stigma and discrimination alongside the implementation of tailored awareness raising initiatives.

The National Mental Health Consumer and Carer Forum has recently highlighted consumer and carer experience of stigma and discrimination across multiple sectors including housing, employment, insurance and within families and the media.[4] Consideration of the structures underpinning these sectors which perpetuate stigma and discrimination is integral to making tangible progress on addressing stigma and discrimination.

Although the NMHC's focus on structural stigma is important, it must not come at the expense of addressing other forms of stigma such as self-stigma and social stigma because all of these forms of stigma are inter-related. For example, Mental Health Australia members have raised the issue of diagnosis-related language and labelling as an important issue requiring further consultation by the NMHC in the development of the Strategy. There are varying views across the mental health sector as to whether diagnosis and therefore labelling of people with specific mental health conditions leads to further stigmatisation or enables greater solidarity, information sharing and peer support amongst people diagnosed with the same condition.

[1] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.361. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[2] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[3] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.361. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[4] National Mental Health Consumer and Carer Forum. (2020). *Advocacy Brief: Stigma and discrimination.* Retrieved 9 November 2021 from **https://nmhccf.org.au/our-work/advocacy-briefs/stigma-and-discrimination**

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This issue was highlighted recently by the Productivity Commission Inquiry into Mental Health's analysis of the 2011 National Survey of Mental Health Literacy and Stigma. The Productivity Commission Final Report explained that the nature of stigma varied between illnesses noting "perceptions of dangerousness, desire for social distance or separation, unpredictability, and a stated preference for not employing someone with a problem, were generally highest for those with schizophrenia."[5] The Productivity Commission Final Report found that between 2003-04 and 2011 there appears to have been a "decrease in the desire for social distance from people with mental illness" in general but also "an increase in perceptions of dangerousness and unpredictability of people living with depression, depression with suicidal thoughts or schizophrenia" specifically.[6] This is an example where diagnosis makes a difference to the types of stigma and discrimination people experience.

The Productivity Commission's Action 8.1, which recommends the development of a National Stigma Reduction Strategy, specifically states the strategy should "focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder."[7]

It will be important for the NMHC to consider the issue of diagnosis-related language and labelling in its development of the Strategy, despite the fact that it does not fit neatly with the focus on structural stigma and discrimination or the draft Guiding Principles, discussed in more detail below. This should include the consideration of stigma and discrimination reduction initiatives which target removal of stigma and discrimination related to specific illnesses.

In short, although Mental Health Australia welcomes the focus on structural stigma and discrimination, Mental Health Australia encourages the NMHC to consider issues which impact across the three forms of stigma and discrimination in developing the strategy.

Recommendation 1: That the National Stigma and Discrimination Reduction Strategy should not exclude examination of important issues relating to self or social stigma.

Draft Guiding Principles

Mental Health Australia welcomes the five draft Guiding Principles, developed by the NMHC and its advisory structures for development of the Strategy:

1. Uphold and protect the dignity and human rights of people who experience mental ill-health and those who support them
2. Respect and promote the personal autonomy, agency and voice of people who experience mental ill-health
3. Value and promote the unique role, needs and experiences of family, friends and support people
4. Understand, respect and respond to culture, identity, intersectionality and community

[5] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.363. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[6] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.363. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[7] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.371. Retrieved 1 November 2020 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**

5. Measure change to drive accountability.

The draft Guiding Principles provide sensible areas of focus for development of the Strategy, which are directly aligned with its overarching vision. Mental Health Australia offers the following advice regarding each of the draft Guiding Principles.

Principle 1: dignity and human rights

Mental Health Australia welcomes the NMHC's framing of stigma and discrimination within a human rights approach. This speaks to Australia's commitments to uphold the rights of Australians under multiple international agreements. This also provides the opportunity for the Strategy to consider issues such as equity of access and opportunity alongside economic dignity.

In developing the Strategy the NMHC should consider whether Australia is meeting its obligations towards people with mental illness under international human rights law and, where it is not, to what extent this is related to structural stigma and discrimination. In doing so the Strategy should list actions Australian Governments can undertake to remove structural stigma embedded in Australian policy and legislation, and assist governments to better meet Australia's obligations under international law.

Following is an example of an issue which could be explored by the NMHC in considering stigma and discrimination through a human rights perspective. The United Nations Convention on the Rights of Persons with Disabilities (which also applies to people with "mental…impairments" [8]), states that States Parties (of which Australia is one) shall "Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner".[9] The recent Productivity Commission Inquiry into Mental Health Final Report highlights stigma and discrimination in the insurance sector as a particular issue. It recommends (among other related actions) that (Action 8.2):

> *"The Australian Law Reform Commission should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information, and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling. The review should include consideration of whether the protocols are sufficient, whether there is a need for legislative change and whether insurance premiums are actuarially fair."*[10]

Recommendation 2: In developing the National Stigma and Discrimination Reduction Strategy the NMHC should consider actions that governments should undertake to remove structural stigma and discrimination embedded in Australian policy and legislation and better meet Australia's obligations under international law.

[8] United Nations. (2006). *Convention on the Rights of Persons with Disabilities.* p.4. Retrieved 15 October 2021 from **https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html**
[9] United Nations. (2006). *Convention on the Rights of Persons with Disabilities.* p.18. Retrieved 15 October 2021 from **https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html**
[10] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.378. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**

Principle 2: personal autonomy, agency and voice

Mental Health Australia welcomes the NMHC's focus on promoting personal autonomy, agency and voice through the Strategy. Mental Health Australia encourages the NMHC to broaden the scope of this guiding principle to ensuring the autonomy, agency and voice of people with lived experience of mental illness is promoted at both a structural and personal level.

The United Nations Convention on the Rights of Persons with Disabilities states that States Parties shall "closely consult with and actively engage persons with disabilities…" in the development and implementation of legislation and policies to implement both the Convention itself and "other decision making processes concerning issues relating to persons with disabilities".[11]

Further, in June 2021 the World Health Organisation released 'Guidance on community mental health services: Promoting person-centred and rights-based approaches'[12] which seeks to assist both organisations and policy development in aligning mental health responses with the Convention on the Rights of Persons with Disabilities.

Including people with lived experience and people who support people with lived experience in leadership and decision making roles would be a demonstrable way in which to tackle myths which lead to stigmatising attitudes. A common misconception is that people experiencing mental ill health and people who care for them do not have capacity to contribute through leadership roles to decision making processes. However, people with lived experience of mental ill health and caring offer unique expertise drawn from this experience. Eliciting this expertise is essential to effective decision making on issues that affect people with mental illness.

The decision making capacity of people with mental illness exists along the full spectrum of decision making capacity, as it does in the general population. It is important that people are supported to the fullest extent possible to make decisions that affect their lives.

Some people with severe mental illness can experience episodic impairments to decision making capacity as a symptom of their illness. In addition, other socioeconomic factors can impact peoples' capacity to make decisions, including age (either being very young or very old), access to information (including culturally appropriate information) and social support.

It is important that even where there are impairments affecting decision making capacity, the greatest effort is made to ensure the will and preference of the person is carried out. This is particularly important where Mental Health Acts (which vary across the country) are used to make decisions for people experiencing mental ill-health. Tools such as Advance Care Directives, and services such as decision support and individual advocacy, can assist people who experience episodic decision making impairment to continue to participate to the greatest extent possible in decision making about their lives. However, access to such tools and services, and their application in the context of the various Mental Health Acts, varies across the country.

[11] United Nations. (2006). *Convention on the Rights of Persons with Disabilities.* p.6. Retrieved 15 October 2021 from **https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html**

[12] World Health Organization. (2021). *Guidance on community mental health services: promoting person-centred and rights-based approaches*. Retrieved 18 October 2021 from **https://www.who.int/publications/i/item/9789240025707**

At an individual level, this aspect of the NMHC's work should consider whether the current legislative, policy, programmatic and financial structures which underpin use or provision of these tools and services currently enable equitable and intuitive access to all people with severe mental illness.

Recommendation 3: The NMHC should broaden the scope of draft Guiding Principle 2 to consider promoting the autonomy, agency and voice of people of all ages and life stages who experience mental ill-health, at both a personal and systemic level. This should include:

- consideration of how to increase the number of people with lived experience of mental ill-health and people who support them in leadership roles
- consideration of how to ensure the greatest effort is made to support the will and preference of people with mental ill-health is carried out in situations where decision making capacity is episodically impaired.

Principle 3: the role of family, friends and support people

Mental Health Australia welcomes the NMHC's acknowledgement that families, friends and support people can also experience mental illness related stigma and discrimination.

Mental Health Australia acknowledges that terminology around those who support people with mental illness is an issue of live debate within the mental health sector. Supporting roles are diverse and varied across family, friends and other support people and it is also important to acknowledge that some people identify both as a person with lived experience of mental ill-health and a support person. In the context of this debate, Mental Health Australia recommends inserting the word 'carer' in addition to other terms used to reference support people in this Guiding Principle. This would ensure that those who consider their primary role in relation to someone with a mental illness is a caring role would also be explicitly included in this work. For the sake of clarity Mental Health Australia recommends the NMHC explicitly state that this guiding principle is referring to unpaid support roles.

It was also reported during Mental Health Australia's consultation that stigma and discrimination is faced by carers that can result in their exclusion from the mental health treatment process of the person they care for.

Recommendation 4: The National Mental Health Commission should include the terminology 'carer' in the scope of draft Guiding Principle 3 and explicitly state that this guiding principle is referring to unpaid support roles.

Principle 4: culture, identity, intersectionality and community

Mental Health Australia welcomes the NMHC's explicit focus on culture, identity, intersectionality and community in the development of the Strategy. Some people

experience stigma related both to mental ill-health and to other aspects of their lives. For example, people with mental ill-health and who belong to the Aboriginal and Torres Strait Islander,[13] LGBTIQ+[14] and culturally and linguistically diverse communities[15] in Australia can be exposed to multiple forms of stigma and discrimination and this can have a significant impact on their mental health. However, to date, there are few mental ill-health related anti-stigma initiatives which are directly tailored for these communities.[16] For this reason, it is crucial that representation from a diverse population is involved in development of the strategy.

In order for the consultation process to be accessible to a diverse population, it should be informed by inclusive design. "Inclusive design makes products, services, spaces, and experiences not only effective and easy to use, but also emotionally positive, accessible to, and usable by people with the widest range of abilities within the widest range of situations without the need for special adaptation or accommodation."[17]

Many organisations are available to assist the NMHC in its consultation process. With this in mind, Mental Health Australia welcomes the NMHC's early engagement with the Embrace Mental Health in Multicultural Australia project. The project has recently commissioned a consortium from the University of Western Sydney, Melbourne University and the University of New South Wales to research mental ill-health related stigma from Arabic and Mandarin speaking communities and people from African backgrounds. Research results are due to be available in April 2022. It will be important for the NMHC to consider this research, alongside other relevant emerging research in development of the Strategy. Mental Health Australia encourages the National Mental Health Commission to contact other key stakeholders in relation to intersectionality in the experience of stigma such as Gayaa Dhuwi (Proud Spirit) Australia and LGBTIQ+ Health Australia if it has not already done so.

In addition, lived experience of trauma can contribute to development of mental illness.[18] Given the connection between trauma and mental illness, and that many people with lived experience of mental illness will participate in the NMHC's consultations, it is important that these consultations are conducted in a trauma-informed way to create safe environments for everyone to contribute. The Mental Health Coordinating Council of NSW has published a Trauma-Informed Events Checklist on its website,[19] which the NMHC may wish to draw on in designing its consultations.

Recommendation 5: To ensure representation from a diverse population in development of the National Stigma and Discrimination Reduction Strategy the National Mental Health Commission should undertake its consultations consistent with both inclusive design and trauma-informed practice.

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[13] Ferdinand, A., Paradies, Y., & Kelaher, M. (2013). *Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey.* Retrieved 9 November 2021 from https://dro.deakin.edu.au/eserv/DU:30058482/paradies-mentalhealthimpacts-2013.pdf

[14] LGBTIQ+ Health Australia. (2021). *Snapshot of mental health and suicide prevention statistics for LGBTIQ+ people.* Retrieved 8 November 2021 from https://www.lgbtiqhealth.org.au/statistics

[15] Ferdinand, A., Paradies, Y., & Kelaher, M. (2015). *Mental health impacts of racial discrimination in Australian culturally and linguistically diverse communities: a cross sectional survey.* BMC Public Health. 15(401)

[16] Morgan, A., Wright, J., & Reavley, N. (2021). Review of Australian Initiatives to reduce stigma towards people with complex mental illness: what exists and what works?. *International Journal of Mental Health Systems, 15(10)*

[17] Patrick, V. & Hollenbeck, C. (2021). Designing for All: Consumer Response to Inclusive Design. *Journal of Consumer Psychology. 31(2). Pp. 360-381*

[18] Australian Government Australian Institute of Health and Welfare. (2020). *Stress and Trauma.* Retrieved 9 November 2021 from **https://www.aihw.gov.au/reports/australias-health/stress-and-trauma**.

[19] See: https://www.mhcc.org.au/project/trauma-informed-care-and-practice-ticp/

In addition, the NMHC should analyse initiatives proposed through the Strategy to ensure they are also inclusive. Initiatives proposed through the strategy should be designed, implemented and evaluated using inclusive design practices and trauma informed practice.

Recommendation 6: The National Mental Health Commission should ensure that any initiatives proposed through the Strategy are designed, implemented and evaluated using inclusive design practices and trauma informed practice.

As the NMHC would already be well aware, there are many other accessibility considerations which will also apply to the Strategy's development. One key consideration, which has evolved recently is the shift to online consultation during the COVID-19 pandemic. This has facilitated easier access for some people while making it more difficult for others to engage. The NMHC should be cognisant of technological barriers and where and when safe to do so offer a mix of engagement methods between online and face-to-face.

Recommendation 7: The National Mental Health Commission should ensure its consultation processes include mixed engagement methods where possible (i.e. online and face-to-face) where it is safe to do so, to ensure those for whom online consultations are inaccessible, are able to provide input.

In addition, Mental Health Australia members have suggested broadening the scope of Guiding Principle 4 to also include consideration of spirituality. Although culture and spirituality are often linked, sometimes they are separate elements in the lives of people with lived experience of mental ill-health and support people. Mental Health Australia members provided examples where health professional stigma around a person's spirituality impacted on a consumer's mental and physical healthcare. This aspect of stigma and discrimination is important to address in the Strategy.

Recommendation 8: The National Mental Health Commission should expand the scope of Principle 4 to also include consideration of 'spirituality' as a basis for stigma and discrimination.

Principle 5: measurement to drive accountability

Mental Health Australia welcomes the NMHC's intention to focus on measurement of reduction in stigma and discrimination to drive accountability. Measuring stigma and discrimination reduction will require:

- regular and comprehensive data collection and analysis on stigma and discrimination prevalence in Australia
- evaluation of the Strategy itself alongside anti-stigma activities
- monitoring and accountability of governments' actions against the strategy.

People with lived experience of mental ill-health and support people should be engaged in all measurement and accountability related activities.

Following is a discussion about each of these forms of measurement.

Evidence informed stigma and discrimination reduction initiatives

Mental Health Australia welcomes the NMHC's approach to broad engagement with a range of experts in developing the strategy, including people with lived experience and support people.

Data on prevalence of stigma and discrimination

In order to gain an accurate understanding of the prevalence and impact of stigma and discrimination, data should be collected and analysed on both:

- experience of stigma and discrimination
- measures across the social determinants of health which could be considered indicators for alleviation of stigma and discrimination.

There is a lack of nationally collated recent data on a large scale indicating the current prevalence of mental illness related stigma and discrimination in Australia.[20] In the absence of national data collection, Sane Australia's Our Turn to Speak survey and National Stigma Report Card offer one of the most comprehensive studies of stigma and discrimination in Australia. The 2020 National Stigma Report Card reported that experience of discrimination for people with complex mental health issues was not only widespread but also frequent.[21]

There is a need for regular national data collection on the experience of mental illness related stigma and discrimination. The Strategy should recommend ways to address this data gap.

Recommendation 9: The National Stigma and Discrimination Reduction Strategy should recommend ways to address the gap in national data on prevalence of mental ill-health related stigma and discrimination.

In addition to collecting data directly on the experience of stigma and discrimination, data should be collected on measures across the social determinants of health which could be considered indicators for alleviation of stigma and discrimination.

For example, participants of Sane Australia's Our Turn to Speak survey reported experiencing stigma and discrimination across 12 life domains including relationships, employment, healthcare services, social media, mental healthcare services, mass media, welfare and social services, education and training, financial and insurance services,

[20] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.362. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**

[21] Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L., and Blanchard, M. (2020). *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues.* Anne Deveson Research Centre, SANE Australia. Retrieved 27 September 2021 from **https://nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf**

housing and homelessness services, cultural, faith or spiritual practices and communities, sports, community groups and volunteering, public spaces and recreation, legal services and justice services.[22] Data relevant to the participation of people with lived experience of mental illness across each of these domains would assist to understand whether the Strategy is resulting in tangible outcomes.

Recommendation 10: The National Stigma and Discrimination Reduction Strategy should outline how it will measure practical progress in addressing structural stigma and discrimination across relevant life domains.

Evaluation of anti-stigma activities

The Strategy should outline a path to evaluate both:

- the effectiveness of the Strategy itself at addressing stigma and discrimination
- individual stigma and discrimination reduction initiatives.

It is important that an evaluation is conducted to ensure the Strategy is resulting in the reduction of stigma and discrimination. The above-mentioned data collection on prevalence of stigma and discrimination and measures across the social determinants of health will provide a valuable source of information to inform this evaluation. However, the evaluation should also take into consideration comparison with international examples of similar strategies to ensure Australia is implementing a truly world class approach to reducing stigma and discrimination.

In addition to evaluating the overall effectiveness of the Strategy, it will be important to continue to build an evidence base on the effectiveness of individual stigma and discrimination reduction initiatives. A recent review of 61 Australian initiatives to reduce stigma found that despite the large number of initiatives active in Australia, evidence of their impact on stigma was lacking.[23] The Productivity Commission Inquiry into Mental Health Final Report also found that:

> *"there is a need to develop an evidence base for effective approaches to stigma reduction. A national stigma reduction strategy would support the development of a national campaign that targets stigmatising views of those with severe mental illness. The strategy should trial different approaches in different areas to identify effective means of stigma reduction, and should include measures of behaviour rather than relying solely on the evidence of stated intentions of survey participants."*[24]

There is a clear need to build the evidence base to ensure the investment of practical effort resulting from the Strategy is reducing Stigma and Discrimination. The above-mentioned

[22] Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L., & Blanchard, M. (2020). *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues.* Anne Deveson Research Centre, SANE Australia. Retrieved 27 September 2021 from https://nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf

[23] Morgan, A., Wright, J., & Reavley, N. (2021). Review of Australian Initiatives to reduce stigma towards people with complex mental illness: what exists and what works?. *International Journal of Mental Health Systems, 15(10), pp.1-51*

[24] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.370. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report.**

two-pronged evaluation approach will assist to measure effectiveness of the Strategy in reaching this goal, alongside the unique contribution of individual initiatives.

Recommendation 11: The National Stigma and Discrimination Reduction Strategy should outline a path to evaluate both the effectiveness of the Strategy itself and individual stigma and discrimination reduction initiatives.

Monitoring and accountability for action

Many government inquiries and research reports have detailed over decades the detrimental impact of stigma and discrimination faced by people with mental ill-health. Through the 5th National Mental Health Plan (Action 18) the Australian Government committed to "take action to reduce the stigma and discrimination experienced by people with mental illness that is poorly understood in the community."[25] Unfortunately, the 2020 Productivity Commission Inquiry into Mental Health found that work committed to by Governments on stigma reduction under the 5th National Mental Health Plan and corresponding implementation plan hadn't been well progressed and that the "recent replacement of COAG [the Council of Australian Governments] with alternative interjurisdictional structures may further delay progress in this area."[26]

Given this recent history, it is crucial that governments are transparent about, and accountable for, implementation of the current Strategy and its outcomes. The Strategy should outline an appropriate interjurisdictional monitoring and accountability process for both the Strategy's implementation progress and its achievement against specific outcomes. This should include consideration of positive incentives to drive action that results in better practice for addressing discriminatory practices.

Recommendation 12: The National Stigma and Discrimination Reduction Strategy should outline appropriate interjurisdictional monitoring and accountability processes for both the Strategy's implementation progress and its achievement against specific outcomes.

Stigma experienced by the mental health workforce

In addition to the issues covered by the five draft guiding principles, the National Stigma and Discrimination Reduction Strategy should address stigma experienced by the mental health workforce. Associative stigma is "stigma that persons experience not because of their own (attributed) characteristics but because they are associated with persons who belong to a stigmatized category in society."[27] Links have been found between associative stigma experienced by mental health professionals and greater depersonalisation, more emotional

[25] Council of Australian Governments. (2017). *The Fifth National Mental Health and Suicide Prevention Plan.* p.40. Retrieved 15 October 2021 from **https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan.**
[26] Australian Government Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 2.* p.367. Retrieved 28 September 2021 from **https://www.pc.gov.au/inquiries/completed/mental-health/report**
[27] Verhaeghe, M. & Bracke, P. (2012). Associative Stigma among Mental Health Professionals: Implications for Professional and Service User Well-Being. *Journal of Health and Social Behavior.* 53(1), pp.17-32, p.18.

exhaustion and less job satisfaction.[28] One study found that in Units where professionals report more associative stigma, people using the service also experienced more self-stigma and less client satisfaction.[29] Mental Health Australia members also raised concerns regarding the impact of associative stigma on workforce development, retention and career progression.

Recommendation 13: The National Stigma and Discrimination Strategy should include consideration of actions to address associative stigma experienced by the mental health workforce.

Conclusion

Stigma and discrimination related to mental ill health is widespread in Australia.[30] It is a major impediment to people with mental illness and the people who support them enjoying the same level of social and economic participation as other Australians. Mental Health Australia's members see this as a priority issue that needs to be addressed. The recent widespread impact of mental ill-health as a result of the COVID-19 pandemic provides a platform for broader engagement that can help inform and underpin the NMHC's National Stigma and Discrimination Reduction Strategy.

This paper has provided initial advice to the NMHC that is intended to inform the development of the Strategy and support tangible movement towards its long term vision that "stigma and discrimination on the basis of mental ill-health are no longer barriers to people living long and contributing lives."[31] Mental Health Australia and our members look forward to continuing to support the NMHC in development of the Strategy.

[28] Verhaeghe, M. & Bracke, P. (2012). Associative Stigma among Mental Health Professionals: Implications for Professional and Service User Well-Being. *Journal of Health and Social Behavior.* 53(1), pp.17-32.
[29] Verhaeghe, M. & Bracke, P. (2012). Associative Stigma among Mental Health Professionals: Implications for Professional and Service User Well-Being. *Journal of Health and Social Behavior.* 53(1), pp.17-32.
[30] Groot, C., Rehm, I., Andrews, C., Hobern, B., Morgan, R., Green, H., Sweeney, L., & Blanchard, M. (2020). Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues. Anne Deveson Research Centre, SANE Australia. Retrieved 27 September 2021 from **https://nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf**
[31] Australian Government National Mental Health Commission. (2021). *National Stigma and Discrimination Reduction Strategy.* Retrieved 13 October 2021 from **https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Stigma-Strategy**

Mental Health Australia

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Mental Health Australia is the peak independent national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
ABN 57 600 066 635

P 02 6285 3100
F 02 6285 2166
E **info@mhaustralia.org**
mhaustralia.org