Draft National Stigma and Discrimination Reduction Strategy

Mental Health Victoria's Submission to the National Mental Health Commission

January 2023

About Mental Health Victoria

Mental Health Victoria (MHV) is the peak body for mental health and wellbeing in Victoria. Our members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health and related sectors. Our aim is to ensure that people living with mental health issues can access the care they need, when and where they need it. Our view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, community, or hospital.

About this submission

This submission provides feedback to the Draft National Stigma and Discrimination Reduction Strategy.

In preparing this submission, MHV has consulted with member organisations, sector stakeholders, mental health service providers, peak bodies, our Lived and Living Experience Advisory Group (LLEAG) and members of our Victorian Mental Health Policy Network (VMHPN) and Service Reform Advisory Network (SRAN).

Introduction

MHV commends the National Mental Health Commission (NMHC) for developing the Draft National Stigma and Discrimination Reduction Strategy (Draft Strategy).

The Draft Strategy provides a systemic approach to reducing stigma and discrimination, and provides the foundation to support the changes needed across community, workplace and service settings, including the mental health and wellbeing system itself. From a Victorian perspective, it is encouraging to see alignment of the Draft Strategy with the intentions and recommendations of the Royal Commission into Victoria's Mental Health and Wellbeing System.

MHV welcomes the objective of the Draft Strategy's vision to take a new, ambitious approach to reduce stigma and discrimination. Specifically, the Draft Strategy shows a deep understanding for the complex impacts that stigma and discrimination have across a range of social settings, and the concurrent actions required to enact the vision of the Draft Strategy.

As identified in the Draft Strategy, the impact of discrimination on those with mental health issues and their carers, families and supporters is profound and presents a significant challenge for social, healthcare and workplace reform. The harms of stigma and discrimination remain a barrier to help-seeking behaviours and recovery, ultimately impacting mental health and wellbeing outcomes. While the Draft Strategy provides a strong foundation to begin to address stigma and discrimination in Australia, the NMHC must consider further refining the feasibility of, and detail associated with, various actions to ensure the Draft Strategy's vision is achieved and supported.

To strengthen the Strategy, MHV proposes the following recommendations, which are subsequently outlined in further detail:

1. Strengthen the Draft Strategy's language, scope and vision
2. Ensure the diverse lived and living experience workforce is supported and embedded in the Draft Strategy
3. Clarify and define the actions for key population groups
4. Enhance the Draft Strategy's focus on alignment with human rights frameworks and legislation where applicable
5. Develop clear steps for data collection, monitoring and evaluation of outcomes
6. Develop a practicable timeframe and implementation plan in consultation with key stakeholders

Recommendation 1: Strengthen the Draft Strategy's language, scope and vision

Overall, the Draft Strategy presents a holistic understanding of experiences and instances of stigma and discrimination and the detrimental impact of this on individuals and communities.

MHV supports the Draft Strategy's recognition of several groups of people who may experience disproportionate and intersectional layers of stigma and discrimination relating to their lived and living experience. In line with the intentions of the Draft Strategy, stigma and discrimination must be understood and recognised across multiple population groups or characteristics to ensure the Strategy's actions adequately address the unique issues facing all members of the Australian community. As such, MHV recommends that the list of groups identified in the Draft Strategy be expanded to also include people seeking asylum or those with refugee backgrounds, people who are neurodiverse, people in contact with the justice system, people who self-harm, and people who are or who have come in contact with the child protection system. We note that our suggested expanded list is non-exhaustive, acknowledging that the nature of stigma and discrimination, and those who experience disproportionate impacts, will shift over time reflecting changes in social, political and cultural settings.

Although the Draft Strategy recognises people experiencing low prevalence and severe mental health issues throughout its actions, we recommend the Strategy refines and strengthens a distinct focus on reducing stigma and discrimination for this specific cohort. Compared to people experiencing high prevalence mental health conditions, people experiencing severe, low prevalence mental health issues are more likely to be subject to unique negative associations, such as violence, by the media, employers, service delivery settings and in broader society.[1] Given the lack of research and evaluation focusing on reducing stigma and discrimination for people with low prevalence and severe mental health issues, MHV recommends an improved focus on this cohort, alongside high prevalence mental health conditions, as a priority through the Strategy's vision.

MHV recommends that the terms *priority populations* and *diverse*, used throughout the Draft Strategy, should be explicitly defined for clarity. Several of the Draft Strategy's action items, including 1F, propose measures impacting priority populations and diverse groups. A comprehensive definition of these terms in the Strategy will help identify the focus for engagement, consultation, research, and transformation initiatives, who should participate in this work, and ultimately who it will impact.

Recommendation 1 summary:

- 1.a. Expand the list of 'multiple and compounding experiences of discrimination' groups in the Strategy to include,
    - People who are seeking asylum or those with refugee backgrounds
    - People who are neurodiverse
    - People in contact with the justice system
    - People who self-harm
    - People who are or have been in contact with the child protection system
- 1.b. Focus the Strategy's vision and actions on people with low-prevalence and severe mental health issues.

[1] Klin, A & Lemish D, Mental disorders stigma in the media: review of studies on production, content, and influences, Journal of Health Communication, 2008 Jul-Aug, vol. 13, no. 5, available: https://pubmed.ncbi.nlm.nih.gov/18661386/

- 1.c. Define the term ‘priority populations’ and ‘diverse’, including who is included as a priority population.

Recommendation 2: Ensure the diverse lived and living experience workforce is supported and embedded in the Draft Strategy

MHV strongly supports the Draft Strategy’s focus on lived and living experience leadership and partnership, including the positioning of the lived and living experience workforce at the centre of tackling stigma and stereotypes. Opportunities for lived and living experience leadership in the workplace (in both declared as well as undisclosed roles) is critical to tackling self-stigma, as well as stigma and discrimination by others in the non-peer workforce. In considering lived and living experience, MHV proposes that the diversity of this experience is also observed and articulated in the Draft Strategy, for example, how lived and living experience varies across age groups, cultures, jurisdictions, care settings, and evolutions of the mental health system over time.

MHV welcomes the recommendation to establish a national professional association for lived and living experience workers, which could provide training, accreditation, support, and advocacy services. A similar recommendation has been repeatedly identified as a critical pillar necessary to support and strengthen the peer workforce across several recent enquiries and strategies, including the Productivity Commission’s Final Report (Action 16.5), the Inquiry into Mental Health and Suicide Prevention Final Report (Recommendation 23) as well as the draft National Mental Health Workforce Strategy (Action 3.4.1).[2] MHV recommends that the Strategy also include details, such as costings, of organisational supports for lived and living experience workers to underpin its implementation. The effectiveness of this Strategy in the implementation phase will rely on a strong, supported and well-resourced lived and living experience workforce to foster change. As such this workforce should be backed by specific action.

MHV also welcomes the Draft Strategy’s focus on addressing self-stigma among the lived and living experience workforce, including the establishment of national and/or regional communities of practice for lived and living experience workers.

With regard to the priority to address and reduce experiences of self-stigma among community members, MHV proposes further exploring the role of lived and living experience workers in the development and implementation of self-stigma reduction programs. Research has repeatedly shown that lived experience involvement is foundational to resilience, self-compassion, social confidence and strengths-based approaches to care in programs and services.[3] Embedding lived and living experience workers within the design, delivery and evaluation of these programs is likely to improve positive recovery outcomes for those experiencing self-stigma and contribute to the reduction of stigma and discrimination.

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[2] Productivity Commission’s Final Report: Mental Health, 2020, available: https://www.pc.gov.au/inquiries/completed/mental-health#report, The Inquiry into Mental Health and Suicide Prevention Final Report, 2021, available: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Mental_Health_and_Suicide_Prevention/MHSP/Report, National Mental Health Workforce Strategy Draft, 2021, available: https://acilallen.com.au/uploads/media/NMHWS-ConsultationDraftStrategy-040821-1628234534.pdf

[3] Byrne, L, Happell, B & Reid-Searl, K, Recovery as a Lived Experience discipline: A grounded theory study, 2015, Issues in Mental Health Nursing, vol. 36, no. 12, available: https://doi.org/10.3109/01612840.2015.1076548

Recommendation 2 summary:

- 2.a. Ensure that all lived and living experience workers receive appropriate support, resourcing, training and protection, including through the establishment of a new national professional association.
- 2.b. Support lived and living experience workers to be at the centre of self-stigma programs and interventions for the public.

Recommendation 3: Clarify and define the actions for key population groups

MHV welcomes the Draft Strategy's focus on specific populations and experiences, including Aboriginal and Torres Strait Islander communities and those with complex mental health needs. This acknowledges the many nuanced, varied and intersectional experiences of stigma and discrimination among the Draft Strategy's priorities.

The Draft Strategy notes that further work may be required to develop tailored approaches for certain population groups and experiences of intersectionality. MHV strongly supports this critical development of actions and strategies to support key population groups, as well as other adjacent sectors such as the AOD, suicide prevention and forensic sectors. Without tailoring actions to focus on all population groups, the full complexity of stigma and discrimination may not be realised, and this could cause barriers to the implementation and ultimate effectiveness of the Strategy.

In the process of tailoring strategies and implementing the Strategy's actions, the NMHC must engage with, and be led by, trusted state and local bodies representing these communities to leverage existing knowledge, partnerships and programs underway. Many existing stigma and discrimination initiatives have built on contact-based and place-based approaches. Continuing to build on strategies that enhance community strengths can cultivate sustainable reductions in stigma and discrimination.

Given the disproportional risk of mental ill-health in LGBTIQA+ Australians compared to their peers related to stigma, discrimination, abuse and vilification, the LGBTIQA+ community and the involvement of community-controlled LGBTIQA+ organisations must be clearly considered in the Strategy.[4] Similarly, addressing stigma and discrimination in culturally and linguistically diverse groups, refugee, asylum seeker and diaspora communities must be considered in the design and delivery of anti-stigma programs. It is critical that the NMHC is led by the expertise of these communities and their lived and living experience to ensure the Strategy's actions are safe, trauma-informed, culturally responsive, inclusive and fit-for-purpose for all communities. MHV recommends that further planning is conducted alongside the implementation process to develop the Strategy's actions appropriately for these groups.

While MHV welcomes the inclusion of children and young people in the Strategy's priorities, we propose that the Strategy further refine its focus on stigma and discrimination experienced by children and their parents or carers who may be experiencing emerging mental health difficulties or who are diagnosed with a mental health disorder. Research has shown that low mental health literacy and experiences of stigma may delay parents or carers in seeking interventions or support for their child as well as for themselves (e.g., parenting

[4] LGBTIQ+ Health Australia, Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ People – 2021, available: https://www.lgbtiqhealth.org.au/statistics

support programs and services).[5] To strengthen the Draft Strategy's approach for children and young people, the NMHC should consider including the stigma reduction and mental health literacy initiatives previously identified in the NMHC's National Children's Mental Health and Wellbeing Strategy.[6]

MHV also recommends the Draft Strategy strengthens its focus on the stigma and discrimination that carers, families and supporters experience across various settings. Carers often face challenges such as social isolation, financial pressures and employment difficulties, in addition to their own mental health challenges.[7] Carers can also experience stigma and discrimination relating to their caring role, both on their own behalf or on behalf of the person for whom they care, within a variety of settings including services, workplaces and the community. A range of approaches to mitigating stigma and discrimination in these settings have been explored by organisations which could be further developed, including flexible workplace policies and events that foster social inclusion. We recommend the NMHC further considers the Draft Strategy's four priority areas to refine approaches to reduce stigma and discrimination for consumers and their carers, families, and supporters.

The Draft Strategy also requires an increased focus on long-term, sustainable funding for community-led organisations representing and supporting key population groups to reduce stigma across all communities. For example, it is fundamental Aboriginal and Torres Strait Islander Community-Controlled Organisations are sustainably resourced to develop self-determined, place-based programs and resources, while mainstream services also work towards embedding the Social and Emotional Wellbeing (SEWB) model and framework within their programs and service delivery. Meaningful choice and access to culturally safe and equitable services from both community-controlled organisations and mainstream services is critical to respecting and embedding human rights practices and reducing discrimination. MHV therefore proposes that the Strategy should include detailed, costed steps to effectively resource community-led organisations and additional actions illustrating how mainstream services will work together to reduce stigma and discrimination with all priority population groups.

Recommendation 3 summary:

- 3.a. Develop actions and strategies for specific key population groups, sectors and experiences.
- 3.b. Partner and engage with people with lived and living experience, community leaders and professionals with expertise in mental health and wellbeing of all key population groups (including those in the draft Strategy and those identified in recommendation 1.a of this submission).
- 3.c. Explicitly identify strategies and actions needed for LGBTIQA+, culturally and linguistically diverse, refugee, asylum seeker and diaspora communities.

[5] Rhodes, M & O'Hara H, Child mental health literacy among Australian parents: a national study, Journal of Paediatric Child Health, 2018, vol. 54, iss. 2, available: https://onlinelibrary.wiley.com/doi/full/10.1111/jpc.13946_21

[6] National Mental Health Commission, The National Children's Mental Health and Wellbeing Strategy, 2021, available: https://www.mentalhealthcommission.gov.au/projects/childrens-strategy

[7] Diminic S, Hielscher E, Harris MG, Lee YY, Kealton J & Whiteford HA, A profile of Australian mental health carers, their caring role and service needs: results from the 2012 Survey of Disability, Ageing and Carers, Epidemiology Psychiatric Sciences, 2019 Dec, vol. 28, no. 6, available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6998876/

- 3.d. Consider including the stigma reduction and mental health literacy initiatives developed previously in the National Children's Mental Health and Wellbeing Strategy.
- 3.e. Strengthen the Strategy's focus on stigma experienced by carers, families and supporters.
- 3.f. Include detailed actions in the Strategy which will resource and support community-led organisations and mainstream services to reduce stigma and discrimination in key population groups.

Recommendation 4: Enhance the Draft Strategy's focus on alignment with human rights frameworks and legislation where applicable

MHV commends the Draft Strategy's emphasis on stigma and discrimination as a human rights issue. Ensuring the human rights of people with lived and living experience are respected in every setting is a necessary and foundational step to tackling structural and public stigma, discrimination and countering negative stereotypes.

MHV recently co-authored 'The Human Rights Roadmap', which offers a suite of 40 pragmatic recommendations to ensure human rights are embedded in the foundations of Victoria's mental health system.[8] Although the Human Rights Roadmap was developed specifically to support the reform of Victoria's mental health system, much of the guidance is relevant to the Draft Strategy's necessary legislative underpinnings.

In line with our Human Rights Roadmap, while MHV welcomes the Draft Strategy's five principles supporting its vision, actions and priorities, we recommend that Principle 1 is refined to ensure it consistently reflects international jurisprudence on human rights obligations to respect, protect and fulfil human rights. MHV recommends the language of the principle should be amended from 'uphold and respect' to 'respect, protect and fulfil'.

MHV broadly supports Priority 1 of the Draft Strategy and the basis of strengthening human rights and protections. The recommended review of the Australian Human Rights Commission Free and Equal project (Action 1b) is a great opportunity, and MHV supports the introduction of a new protected category for mental-ill health and suicide. We propose that this category should additionally include trauma due to its clear impacts on mental health and wellbeing, as well as trauma caused by discrimination and stigma.[9] A person's traumatic experiences, such as experiences of historical events, asylum seeking or racial discrimination, may give rise to discrimination across certain settings and the diversity of trauma should be recognised to improve human rights and anti-discrimination protections.

At present, discrimination law is based on individual complaint processes which can be difficult and burdensome to pursue and may mask the impact of discrimination on groups at community and population levels. MHV recommends that the NMHC explores improved, safe and accessible channels for reporting mental health-related discrimination. Leveraging place-based initiatives in the community and resourcing targeted initiatives for key

[8] Mental Health Victoria and the Castan Centre for Human Rights Law, The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system, 2022, available: https://www.mhvic.org.au/images/policy/MHV2022_Castan_Report.pdf

[9] Phoenix Australia, Research Publications on Trauma and Mental Health, 2022, available: https://www.phoenixaustralia.org/research/research-publications/

population groups (see recommendation 3.b and 3.f above) are actions that may improve education and reduce barriers in complaint processes.

Further, MHV welcomes the NMHC's action to review and amend mental health legislation across states and territories in alignment with international human rights frameworks and obligations. Compliance between Australian and international frameworks have historically been an iterative and often slow process. We emphasise that work for this action must be ongoing, beyond the medium-term timeframes identified in the Draft Strategy.

Recommendation 4 summary:

- 4.a. Amend the Strategy's language to reflect appropriate international jurisprudence by including 'respect, protect and fulfil' in Principle 1.
- 4.b. Include trauma as a part of the new protected category for mental-ill health and suicide in Action 1b.
- 4.c. Explore accessible and safe complaint processes that do not burden individuals.

Recommendation 5: Develop clear steps for data collection, monitoring and evaluation of outcomes

As identified in the Draft Strategy, a major challenge in understanding the prevalence of stigma and discrimination in Australia is the lack of existing data, research and strategic action. Similarly, there has been limited evaluation and monitoring to understand the impact of stigma reduction initiatives and strategies to date.

MHV welcomes the NMHC's proposal to collect ongoing, population-level data to improve understanding of stigma and discrimination in Australia. To this end, we recommend that Priority 1 of the Draft Strategy is expanded to explicitly include research studies.

MHV notes that many of the actions relating to data collection and monitoring will be undertaken within a short to medium timeframe (1 to 3 years). The actions to collect data will occur at the same time as implementation of other proposed actions in the Draft Strategy. Given the immediacy of the timeframe, the NMHC should clearly outline how data collection and monitoring will be conducted. The NMHC must ensure data collection, monitoring and evaluation is developed sustainably so that it can be undertaken on a long-term basis to capture how experiences of stigma and discrimination may change over time, and to measure the impact and effectiveness of initiatives implemented from this Strategy. In turn, this evidence will inform future stigma and discrimination reduction work.

MHV also supports the Draft Strategy's actions to conduct research into the prevalence of self-stigma across four identified core categories of people (people with personal lived experience; families and support people; lived experience workforce; and the general population). To improve research into self-stigma, MHV recommends that the NMHC expands the categories of self-stigma research to include those identified in the groups of 'multiple and compounding experiences of stigma and discrimination' in the Draft Strategy, as well as those identified in recommendation 1.a of this submission. As a person's intersectional, social, geographical and personal characteristics can underpin their experiences of self-stigma, this would be a valuable first step in developing this evidence base. As a result, this data could help inform the development of programs that reflect the culture, place and community in which a person experiencing self-stigma belongs.

Recommendation 5 summary:

- 5.a. Clearly identify research studies as a form of data collection.
- 5.b. Examine how the timeframes for data collection and monitoring will be met in the long-term and how it will fit with other actions in the Strategy.
- 5.c. Ensure self-stigma research and evaluation are conducted into all key population groups.

Recommendation 6: Develop a practicable timeframe and implementation plan in consultation with key stakeholders

The Draft Strategy presents a commendable plan for stigma and discrimination reduction, however the execution of the proposed actions is crucial. To achieve real reductions in instances of stigma and discrimination across Australia's diverse communities, the implementation and evaluation of the Strategy's actions must be conducted in a robust, collaborative, and sustainable way.

MHV recommends that the NMHC develops a clear implementation and communication plan to provide guidance and necessary detail underpinning the actions set out in the Draft Strategy. These plans should also address issues of resourcing and sustainability, and identify the key stakeholders to be engaged, consulted and involved. The implementation plan should be informed by implementation science literature and expertise, and consider governance, planning, collaboration, communication, capacity-building, monitoring, and evaluation, as identified in MHV's co-authored 'Vision to Reality' implementation guide.[10]

There will also need to be coordinated efforts across federal, state, territory and local governments for the full implementation of the Strategy's actions to be realised. National consistency in efforts to reduce stigma and discrimination, including a coordinated approach to implementing each action, must be underpinned by ongoing partnerships and accountability mechanisms. Failing to achieve a coordinated approach is likely to jeopardise the effectiveness and impact of the Strategy's actions and initiatives. To this end, the NMHC should identify and leverage existing partnerships and programs which exist across all levels of government and community to ensure implementation builds on the strengths already in place in the community, while facilitating cooperation and coordination between federal, state, territory and local bodies.

MHV also recommends that the NMHC considers the importance of special measures (commonly referred to as *positive discrimination* or *affirmative action*) in the Draft Strategy and identify how these will apply to the implementation of the Strategy. As identified by the Australian Human Rights Commission, positive measures may be necessary to foster greater equality for those who face discrimination to ensure similar access to opportunities.[11] For example, measures such as special consideration for people with lived and living experience of mental ill-health in workplaces or educational settings may be necessary to

[10] Mental Health Victoria and the Victorian Healthcare Association, From Vision to Reality: A guide for the successful implementation of recommendations from the Royal Commission into Victoria's Mental Health System, 2020, available: https://www.mhvic.org.au/images/RoyalCommission/VS0040MHVRoyalCommissionVisiontoRealitySubmissionSinglePages.pdf

[11] Australian Human Rights Commission, Quick Guide: Positive Discrimination, 2022, available: https://humanrights.gov.au/quick-guide/12078

address existing discrimination and improve equity in opportunities. Incorporating this terminology and considering which actions may need to include special measures to reduce inequitable outcomes has the potential to bolster the existing stigma and discrimination reduction actions to benefit the Strategy's vision and implementation.

MHV further proposes that the Strategy should explicitly recognise the significant work that has been, and is being undertaken, in the mental health and wellbeing sector to reduce stigma and discrimination. Building on previous and existing initiatives, research and campaigns will be vital in avoiding replication and duplication, while supporting much needed change. Existing work includes the anti-stigma and discrimination reduction reforms underway in Victoria as a result of the Royal Commission into Victoria's Mental Health System. Bodies like the new Victorian Mental Health Commission will play a significant role in designing and delivering initiatives to address stigma in Victoria, and the Strategy would benefit from aligning with such efforts.

Social movements and changes that underpin stigma and discrimination will involve long-term cultural change. While the Draft Strategy provides an indicative timeframe of one to five years to implement the proposed actions, change is not likely to be reflected in societal views and behaviours for years to come. As such, MHV proposes the NMHC should further examine the Draft Strategy's current timeframes where appropriate to achieve its vision.

Recommendation 6 summary:

- 6.a. Create a detailed, robust implementation plan which is informed by best practice and supports the actions in the Strategy.
- 6.b. Identify opportunities to coordinate efforts across federal, state, territory and local levels of government to ensure adequate implementation and accountability of the Strategy's actions.
- 6.c. Include and define how special measures (also known as positive discrimination or affirmative action) relates to the vision and implementation of the Strategy.
- 6.d. Identify and build on previous and current work in stigma and discrimination reduction.
- 6.e. Evaluate the feasibility of the Strategy's timelines on an ongoing basis.

Conclusion

The Draft Strategy presents a clear and commendable approach to addressing mental health-related stigma and discrimination in Australia. The implementation of the final version of the Strategy will be a critical step at a national level in supporting and strengthening the human rights of people with lived and living experience of mental health issues, including families, carers and supporters. If realised, the long-term vision will see a transformed culture across Australia with greater instances of compassion, respect, dignity and freedom from discrimination.

To deliver the Strategy's vision, MHV urges the NMHC to consider the recommendations proposed, and refine and expand various actions, language and the vision underpinning the Strategy. We encourage the NMHC to leverage existing local and community partnerships and programs, and identify existing stigma and discrimination reduction work already underway. We suggest that the NMHC also develops specific actions and approaches for key population groups, to ensure the Strategy can positively impact all Australians. The

leadership by, and partnership with, key population groups will be critical to the realisation of the vision outlined in the Strategy.

Achieving change will require consistent funding and continuing partnerships, monitoring and evaluation of the Strategy's initiatives. National consistency and transparency on stigma and discrimination reduction initiatives and impact will take time. We also encourage the NMHC to consider a sustainable timeline for implementation.

MHV thanks the NMHC for the opportunity to contribute to this vital piece of work and welcomes the opportunity to provide more detailed advice as the final Strategy is developed.

Sincerely,

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