National Stigma and Discrimination Reduction Strategy

Draft for Consultation

9 November 2022

Australian Government
National Mental Health Commission

National Stigma
& Discrimination
Reduction Strategy

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We need your feedback

This document is the (Draft) National Stigma and Discrimination Reduction Strategy.

Public consultation on this Draft Strategy will be open from 9 November 2022 for a period of twelve weeks to 1 February 2023.

We invite input and feedback to strengthen the Draft Strategy and its proposed actions. In doing so, we invite consideration of the following questions:

- **Feasibility**: Are the actions achievable in the recommended timeframe and allocated to the correct responsible party/parties? Is there a readiness for change?
- **Enablers**: What might support the actions and/or assist the work needed to implement the change?
- **Barriers**: What might slow down or prevent the gaining of support for the actions, or their implementation?
- **Effectiveness**: Will the actions lead to the changes we want to see? Are there any potential unintended consequences?
- **Anything missing**: Are there any critical issues or actions to address stigma and discrimination that are not referenced or sufficiently prioritised in the Draft Strategy?

For further information about how to provide feedback, please visit our website at: https://mentalhealthcommission.gov.au/StigmaStrategyDraftConsultation

Acknowledgement of Country

The National Mental Health Commission respectfully acknowledges and celebrates the Traditional Owners of the Lands and Waters throughout Australia and pays its respects to their Elders past and present.

We acknowledge that Aboriginal and Torres Strait Islander people have a unique experience of stigma and discrimination. The insights of Aboriginal and Torres Strait Islander people and communities have been important in developing this (Draft) Strategy.

Thank you

The National Mental Health Commission (the Commission) would like to acknowledge and thank the people who have been involved in shaping this (Draft) Strategy: those with lived or living experience of psychological distress or mental ill-health, voluntary and involuntary service use and/or diagnosis, trauma, suicide, and those who identify as neurodiverse. We also acknowledge and thank family, friends, unpaid carers and support people for their contributions.

We acknowledge the expertise which comes with lived experience as distinct and uniquely important in shaping a future free of stigma and discrimination. The (Draft) Strategy could not have been developed without the input, time and expertise offered by a diverse range of people with lived experience and those who support them.

The (Draft) Strategy builds on a body of existing knowledge and labour led by people with lived experience and we acknowledge their contributions as a central underpinning for this work. Many people have worked tirelessly to create a better society for themselves and others, embedding unique and diverse perspectives to which we have sought to do justice. This includes the insights and perspectives from people who do not identify with the label of mental ill-health but who have been diagnosed by the mental health system.

Many others have made invaluable contributions by offering insights and through engaging with and challenging our ideas at many points during the development of the Strategy. We would like to thank everyone who reflected on their own experiences and expertise to provide feedback and input so far.

Our immense gratitude goes towards the members of our Steering Committee, co-chaired by Tim Heffernan and the Hon. Professor Kevin Bell AM KC, and Technical Advisory Groups, whose guidance, feedback, and critiques have been essential in bringing the Draft Strategy to this stage. A full list of members can be found at Appendix A and on our project website.

We look forward to continuing these collaborations as we work to refine the Strategy into its final form for government consideration.

Contents

Background to the Strategy

The need to protect and promote the human rights of people who experience mental ill-health has long been championed by the consumer and carer movement. The case for change was articulated clearly in the seminal 1993 National Inquiry into the Human Rights of People with Mental Illness, which played an important role in raising awareness about systemic discrimination faced by people experiencing mental ill-health.[1] The experience of the past three decades tells us that while some progress has been made, there is an urgent need to do more.

In 2020, the National Federation Reform Council tasked the National Mental Health Commission with developing a national stigma-reduction strategy. This work was a response to the Productivity Commission Inquiry into Mental Health, which recommended that "*the National Mental Health Commission should develop and drive the implementation of a renewed national long-term stigma reduction strategy*"[2] and is reflected in the National Mental Health and Suicide Prevention Agreement[3] agreed to by Australian, state and territory Governments. It is also consistent with actions recommended in the Fifth National Mental Health and Suicide Prevention Plan 2017-2022, including Action 18, which states that "*governments will take action to reduce the stigma and discrimination experienced by people with mental illness that is poorly understood in the community.*"[4]

This (Draft) Strategy is the first government-led national strategy to take a comprehensive and systemic approach to addressing mental health-related stigma and discrimination in Australia. In doing so, it brings a renewed focus to efforts to do more to uphold the human rights of people with personal lived experience and their families, carers and support people. This (Draft) Strategy outlines **a long-term vision for an Australian community where everyone has equal dignity, respect and value and is able to live a life of meaning and purpose free from mental health-related stigma and discrimination.** It builds on existing efforts and insights and draws on a range of other inputs, including background papers, evidence reviews and stakeholder engagement, to generate actions that can be readily implemented to effect change at an individual, societal and structural level.

Central to the (Draft) Strategy's development has been bringing together diverse perspectives, with leadership throughout the Strategy development process from people who have experienced mental health-related stigma and discrimination. In particular, this has included thought leadership, advice and feedback from the project's Steering Committee and Technical Advisory Groups (listed at Appendix A), each of which was co-chaired by someone with personal lived experience and someone with another form of expertise. Similarly, members brought different lived experiences and/or academic, sector and/or other specialist expertise. This intentional approach to authentic collaboration has been critical to ensuring a diverse range of perspectives are being considered and shaping the Strategy's development.

The (Draft) Strategy seeks to align with other strategies and frameworks currently in place to drive improvements across Australia's communities, policy settings and service landscapes in a range of areas, such as *Closing the Gap*, *Australia's Disability Strategy 2021-2031* and the *National Preventive Health Strategy 2021-2030*, as well as various service standards and workforce strategies. In doing so, the (Draft) Strategy highlights the ways in which stigma and discrimination on the basis of mental ill-health can be addressed by leveraging and building on these and other existing reform efforts. It is noted that additional work may be needed in some places to develop tailored mental health strategies (that include stigma-reduction objectives) for specific populations and aspects of intersectionality, such as culturally and linguistically diverse communities, people in forensic mental health settings and people who have experienced gambling harm or experience of alcohol or other drug issues.

The (Draft) Strategy puts forward a case for immediate and enduring effort to reduce stigma and discrimination towards people who experience mental ill-health, trauma, distress or suicidality (people with personal lived experience) and their families, friends, unpaid carers and support people (families and support people). It provides a clear vision for the future, underpinned by guiding principles. The (Draft) Strategy sets out four priorities, each supported by clear objectives and a series of implementable and measurable actions. These actions are directed towards the Australian Government, state, territory and local governments, industry and the community generally.

An indicative timeframe is provided for implementation of each of the proposed actions in the short term (within 1 year), medium term (1 year to 3 years) or long term (3 years to 5 years).

Indicative Timeframes for Action

Short Term	Medium Term	Long Term
Within 1 year	1 to 3 years	3 to 5 years

Changes to the mindsets or behaviour that underpin stigma and discrimination require long term cultural change. While this (Draft) Strategy outlines actions required over the next five years, we anticipate that subsequent Strategies will be required to cement the actions undertaken and to drive change over a sustained period.

Language matters

People make sense of their experiences in different ways and may have different preferences for how they would like their experiences described. Not having these preferences respected can itself be stigmatising. Language can have negative impacts and/or divide people by the way it is used and understood, particularly when it is used to stigmatise or label.

In drafting the Strategy, we have tried to choose terms that are meaningful to a wide range of people. We chose this language after long consideration and discussion with people with lived experience. We acknowledge that the language the Strategy uses is ultimately imperfect to describe the deeply personal lived experience of stigma and discrimination.

Key terms used in the (Draft) Strategy

Common terms used throughout this document are defined in the glossary at Appendix B in the full (Draft) Strategy. In this (Draft) Strategy summary, each of these terms is used in the context of, or relating to, people with a lived experience of psychological distress, mental ill-health, voluntary or involuntary service use, trauma, suicidality and alcohol and other drug issues, and their families, friends, unpaid carers and support people.

People with personal lived experience

“People with personal lived experience” describes people with a lived or living experience of psychological distress, mental ill-health, trauma, suicidality, suicide attempt and alcohol and other drug issues. It is recognised that there is diversity in personal experiences of mental health and wellbeing, noting that mental health is experienced on a spectrum and across a lifetime, and experiences of mental ill-health may be different for different people at different times.

Families and support people

“Families and support people” describes families, kinship networks, friends, unpaid carers and anyone whose primary relationship with the person concerned is a personal, supporting and caring one.

Social and emotional wellbeing

The (Draft) Strategy recognises the diversity of ways that people and communities understand, conceive of and describe mental health. In particular, we recognise that the term ‘mental health’ does not fully describe the experiences of many Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. The term “social and emotional wellbeing” is used by many Aboriginal and Torres Strait Islander people to describe their social, emotional, spiritual, and cultural wellbeing. It acknowledges the importance of connection to community, family, land, sea, culture, and spirituality on their wellbeing.

Lived Experience workforce

Consistent with the *Lived Experience (Peer) Workforce Development Guidelines,*[5] the (Draft) Strategy uses “the Lived Experience workforce” as a collective term for people working in personal lived experience roles and in family/carer roles. It is recognised that these are separate workforces, informed by different types of understandings and experiences and with distinct ways of working.

Understanding stigma and discrimination

Stigma is complex, arising from a range of cultural, social, political and psychological processes. Stigma can include negatively stereotyped characteristics, attitudes, and responses, which harm a person's day-to-day health and wellbeing by excluding, devaluing, or shaming them.[6]

Stigma can lead to discrimination – that is, unfavourable treatment (direct discrimination) or policies and systems that disproportionately disadvantage people (indirect discrimination) because of certain personal characteristics or attributes. In some cases, discrimination can be against the law, as set out under Commonwealth and state/territory anti-discrimination laws, as well as other legal and regulatory arrangements.[7]

Mental health-related stigma and discrimination plays out in a range of ways. For example, when people assume that anyone with personal lived experience is dangerous, or incapable of work or maintaining relationships, and/or caring for children. Mental health-related discrimination mean people being denied access to essential services like housing or financial support, or employment, because of their lived experience or role as a family member, carer or support person. There are many other ways in which this occurs. These are discussed further throughout the (Draft) Strategy.

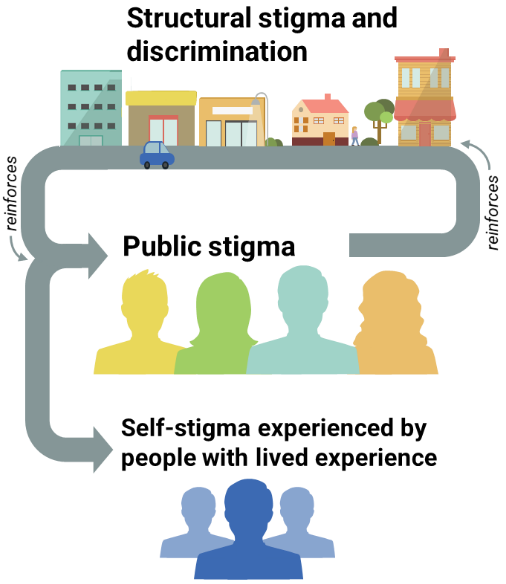
Structural stigma refers to when laws, policies, practices and organisational structures enable unfair treatment of people with personal lived experience, and their families and support people. This includes the unintended consequences of practices and structures that make it much harder for people with lived experience to access vital services and to participate in society.

Types of Stigma

The (Draft) Strategy broadly categorises stigma into three categories:

- Structural stigma
- Public stigma
- Self-stigma

The definitions of each of these categories draw on academic literature and are listed below. Different forms of stigma can occur alongside each other. This is demonstrated in the diagram on this page. It is important to understand that actions in one area can generate benefits in another.



Structural Stigma

When laws, policies, practices and organisational structures enable unfair treatment of people with personal lived experience, and their families and support people.[8] This includes the unintended consequences of practices and structures that make it much harder for people with lived experience to access vital services and to participate in society.

Public stigma

Negative thoughts, feelings, opinions and behaviours held or expressed by individuals or organisations towards people with personal lived experience and their families and support people.[9]

Self-stigma

The process in which a person with personal lived experience becomes aware of public or structural stigma, agrees with those stereotypes, and internalises them by applying them to the self. The person comes to believe these negative messages or stereotypes about mental ill-health and applies these to themself.[10] Families and carers can also experience self-stigma.

Multiple and compounding experiences of stigma and discrimination

There are multi-faceted, mutually reinforcing relationships between different sources of stigma. People with certain experiences or who belong to certain groups or communities are often disproportionately affected by stigma and discrimination relating to their personal lived experience. These people's experiences of mental health-related stigma and discrimination are often amplified by other forms of discrimination.

These include the following groups of people:

- **Aboriginal and Torres Strait Islander people and communities**: Colonialism, racism, paternalism, persistent disadvantage, systemic injustice and lack of acknowledgement of culture have resulted in stigma and discrimination toward Aboriginal and Torres Strait Islander people. This discourages Aboriginal and Torres Strait Islander people from seeking support for their social and emotional wellbeing.[11]

- **People from culturally and linguistically diverse communities, including new migrants and humanitarian entrants**: Stigma and discrimination related to cultural or ethnic background impacts mental health and wellbeing of people in these communities. However, the factors associated with mental health-related stigma and discrimination in culturally and linguistically diverse groups are less well known.[12] There are often different conceptualisations around mental ill-health, trauma and wellbeing, and other barriers to accessing services, based on cultural, linguistic, religious, and/or spiritual factors. This means people can experience stigma related to mental ill-health from both outside and within their families and communities.[13]

- **Family, friends, unpaid carers and support people**: Stigma by association involves disapproval towards those who associate with people whose experiences are stigmatised.

- **LGBTIQA+ people**: Lesbian, gay, bisexual, trans, intersex, queer and asexual people face stigma and discrimination related to their sexual orientation, gender and sex characteristics. Being subject to stigma and discrimination can negatively impact mental health and wellbeing. This adds an additional layer of risk on top of biological, social, environmental and psychological factors which negatively impact mental health and wellbeing.[14]

- **People with lived experience of suicide**: Suicidality and suicidal behaviour is not well understood by the community and can lead to stigma. This can discourage people from disclosing their suicidality and impair willingness to seek help.[15,16] People who have experienced suicidality and those supporting them, as well as those who are bereaved by suicide, can experience stigma and discrimination.[17] Not all people who experience suicidality and suicidal behaviour have experienced mental ill-health, however, a high proportion have.

- **People with lived experience of alcohol and other drug issues or gambling harm**: Alcohol and other drug use, and/or gambling, can be viewed unhelpfully as a moral failing rather than a public health issue.[18] This can lead to experiences of shame, blame and punishment for people with lived experience of alcohol and other drug issues or gambling harm.[19]

- **People with disability or chronic illness**: The result of the interaction between a person's disability or chronic illness and social, attitudinal, and environmental barriers can hinder their full and effective participation in society. People with co-occurring physical and psychological health needs often anticipate stigma and avoid seeking support for either condition.

- **People who do not fit socio-cultural stereotypes of body size, shape, weight:** Weight stigma can have an impact on a person's experience of care and support for both physical and mental health problems.[20]

- **People experiencing financial distress, income support recipients and people living in social housing**: Unemployment, receipt of social welfare, financial distress and poverty are associated with experiences of stigma and discrimination. This form of stigma and discrimination extends beyond those with personal lived experience to their families and support people. Carers of people with mental ill-health can be disadvantaged with limited access to employment or welfare payments.[21]

- **New mothers**: The postpartum period is a particularly vulnerable time, where many new mothers experience mental ill-health, which can be distressing and stigmatising. This stigma stems from deeply embedded societal romanticism of mothers to a new baby, and pregnancy, as "times of nearly uninterrupted joy and rewarding sacrifice."[22]

- **Children, younger people and older adults**: Stereotypes about age can inform perceptions of people as vulnerable, frail, dependent or needing protection. These beliefs can intersect with mental health related stigma. For example, the belief that some mental health problems like depression are a natural part of ageing can directly influence treatment-seeking, diagnosis, access to services, and social isolation.[23,24]

- **People living in regional, rural and remote areas**: Stigma is commonly cited as a barrier to help-seeking in small or close-knit communities, such as in rural and remote areas, where people knowing each other can give rise to concerns about privacy and confidentiality, particularly around face-to-face services.[25] There is also limited access to – and therefore choice between – specialised, quality mental health services in these areas, which can compound negative experiences of services.

Stigma and discrimination are experienced differently for people who identify with multiple populations or characteristics, including those outlined above. It is important for us to understand how aspects such as race, gender, sexuality, disability status, neurodiversity, culture, and class intersect to create overlapping, mutually reinforcing, and compounding systems of discrimination and disadvantage for individuals and communities. This is understood as intersectionality and can be further explored by examining systemic notions of power, structural disadvantage, and privilege.

Why is action needed?

Action is needed to build a society and culture where all people in Australia, including those who have experienced mental ill-health, trauma, distress or suicidality, have equal dignity, respect and value and are able to live a life of meaning and purpose free from mental health-related stigma and discrimination.

Australia's obligation to uphold and protect human rights

Australia has committed to the full and equal enjoyment of all human rights for all people, including for people with personal lived experience and their families and support people. The ratification of the *Convention on the Rights of Persons with Disabilities*, in 2008 by the Australian Government reaffirmed and strengthened this commitment. This Convention "clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced." While not all who experience mental ill-health or distress would conceptualise their experiences as disabilities, this Convention adopts a broad definition which is inclusive of experiences of mental ill-health.

Stigma and discrimination represent a threat to this commitment, and to a free and fair community for all. They do so by denying the fundamental rights and freedoms that all people are entitled to enjoy and exercise.

The right of people with personal lived experience to have their dignity respected is not negotiable.

Ongoing negative impacts of stigma and discrimination

People with personal lived experience and their families and support people have long reported that stigma and discrimination negatively impact their lives.[26] This is particularly the case for people who experience complex or multiple unmet mental health needs, including those who experience psychosis or who have been diagnosed with schizophrenia, personality disorders, and eating disorders.[27,28,29]

Research indicates that stigma and discrimination continue to have a significant impact. People can fear they will be stigmatised, which in turn becomes a barrier to social, economic, and cultural participation.[30] Stigma and discrimination are also harmful due to the distress they cause the individual.[31]

A new approach to address stigma and discrimination

Existing initiatives aimed at reducing stigma and discrimination have had no proven or only limited success. And while there are some positive results for individual programs, our research involving people around the nation shows three out of five people with personal lived experience reported experiencing unfair treatment or discrimination. [32]

A new approach is needed which upholds everyone's right to live in a society free from stigma and discrimination. The (Draft) Strategy seeks to shift the dial by driving positive change within the systems, structures, policies and practices which embed stigmatising attitudes and discriminatory treatment. This is important because it seeks to set up a system that will compel *behavioural* change even if there is no underlying shift in the community *attitudes*.

This new approach also takes into account different experiences of mental ill-health and specific cultural and social contexts. More inclusive approaches, in attitudes and behaviours, have the potential to benefit everyone, creating spaces for more equitable and diverse participation and contributing to cohesion and better-quality outcomes.

This new Strategy puts forward a vision for an Australian society free of mental health-related stigma and discrimination. It sets out four overarching priorities:

- To implement foundational actions across settings to address stigma and discrimination
- To reduce structural stigma and discrimination
- To reduce public stigma
- To reduce self-stigma.

Our vision

VISION

An Australian community where everyone has equal dignity, value and respect and is able to live a life of meaning and purpose free from mental health-related stigma and discrimination.

Living a life of meaning and purpose can mean many things. It can mean a fulfilling life enriched with close connections to family, friends, and community; good health and wellbeing to allow those connections to be enjoyed; having something to do each day that provides meaning and purpose – whether it be a job, hobby, supporting others or volunteering; and a home to live in, free from financial stress and uncertainty. It can also refer to holding close connections to kin and country, family and friends, and full expression of culture and identity.

What an Australian society free of stigma and discrimination would look like

This (Draft) Strategy envisages an Australia free of all forms of mental health-related stigma and discrimination towards people with personal lived experience, and towards their families and support people.

This stigma-free Australia is a society where all people are valued and treated with dignity and no one feels ashamed of any aspect of their mental health or wellbeing, or of that of their loved ones. People feel comfortable to openly speak about mental health as a normal part of life without a sense of shame, embarrassment or fear of exclusion. Policies, programs, practices, systems, laws and regulations and their enactment across all areas of society can not only prevent discrimination towards people with personal lived experience, but promote and uphold their human rights. As articulated by the people with personal lived experience who contributed to developing the (Draft) Strategy, a stigma-free society means all people in Australia understand that people with personal lived experience are valued members of society who have something to offer. Society is enriched by their participation.

Principles to guide the (Draft) Strategy

The following five principles have been used to guide the (Draft) Strategy’s priorities, objectives, and actions.

These principles were agreed to by the Strategy‘s Steering Committee and Technical Advisory Groups.

1. **Uphold and protect the dignity and human rights of people with personal lived experience and those who support them**

Full enjoyment of human rights requires the elimination of mental health-related stigma and discrimination.

When a person experiences stigma or discrimination related to their personal lived experience or their association with someone with that experience, their right to freedom from discrimination is impinged. Human rights are indivisible, interdependent, and interrelated – meaning that the enjoyment of any individual right is contingent on the enjoyment of other rights – discrimination can interfere with the enjoyment of a wide range of other human rights.

2. **Respect and promote the personal autonomy, agency, and voice of people with personal lived experience, and their leadership role in all aspects of the Strategy**

Reducing stigma and discrimination means that people with personal lived experience make decisions about their own care and other important matters which affect their lives.

3. **Value and promote the unique role, needs and experiences of family, friends, unpaid carers, and support people**

Reducing mental health-related stigma and discrimination includes reducing stigma and discrimination experienced by families, carers, and supporters of those with personal lived experience. Families and support people should not be treated unfairly or differently to others on the basis that their caring or support role relates to mental health.

4. **Understand, respect, and respond to culture, spirituality, identity, intersectionality, and community**

Stigma reduction efforts must consider and address how overlapping forms of discrimination and marginalisation can impact an individual or community, compounding the effects of mental health-related stigma and discrimination.

5. **Measure behavioural change to drive accountability**

Stigma reduction efforts must draw on ongoing evidence and be accompanied by robust and sustained monitoring and evaluation to ensure they are effective. Transparency and accountability in relation to both effort and outcomes are ingredients themselves for change.

An overview of the (Draft) Strategy

VISION

An Australian community where everyone has equal dignity, value and respect and is able to live a life of meaning and purpose free from mental health-related stigma and discrimination

PRINCIPLES

1. Uphold and protect the dignity and human rights of people with personal lived experience and those who support them
2. Respect and promote the personal autonomy, agency, and voice of people with personal lived experience, and their leadership role in all aspects of the Strategy
3. Value and promote the unique role, needs and experiences of family, friends, unpaid carers, and support people
4. Understand, respect, and respond to culture, spirituality, identity, intersectionality, and community
5. Measure behavioural change to drive accountability

PRIORITY 1
Implement foundational actions across settings to address stigma and discrimination

1.1 Strengthen human rights and anti-discrimination legislation

1.2 Strengthen accountability mechanisms

1.3 Embed lived experience leadership and advocacy

1.4 Educate and train key cohorts and workforces to build their capacity to deliver critical services free from stigma and discrimination

1.5 Improve the evidence base through data collection and evaluation

PRIORITY 2
Reduce structural stigma and discrimination

2.1 Require the mental health system to provide safe and empowering environments for people seeking services

2.2 Ensure equity of access to quality healthcare

2.3 Ensure social services, including social security, housing and child protection, are available, equitable and non-discriminatory

2.4 Support people to have equitable access to financial services and insurance

2.5 Support people to receive equitable treatment by legal systems

2.6 Build equitable and supportive pathways into and within employment

2.7 Improve mental health capabilities and supports in education and training settings

PRIORITY 3:
Reduce public stigma

3.1 Build a social movement to catalyse community action to reduce stigma and discrimination

3.2 Improve the quality of media reporting and representations of mental ill-health

PRIORITY 4:
Reduce self-stigma

4.1 Address self-stigma through public stigma reduction initiatives

4.2 Address self-stigma amongst the Lived Experience workforce

4.3 Introduce measures to reduce self-stigma among families and support people

4.4 Strengthen the evidence base for initiatives to reduce self-stigma

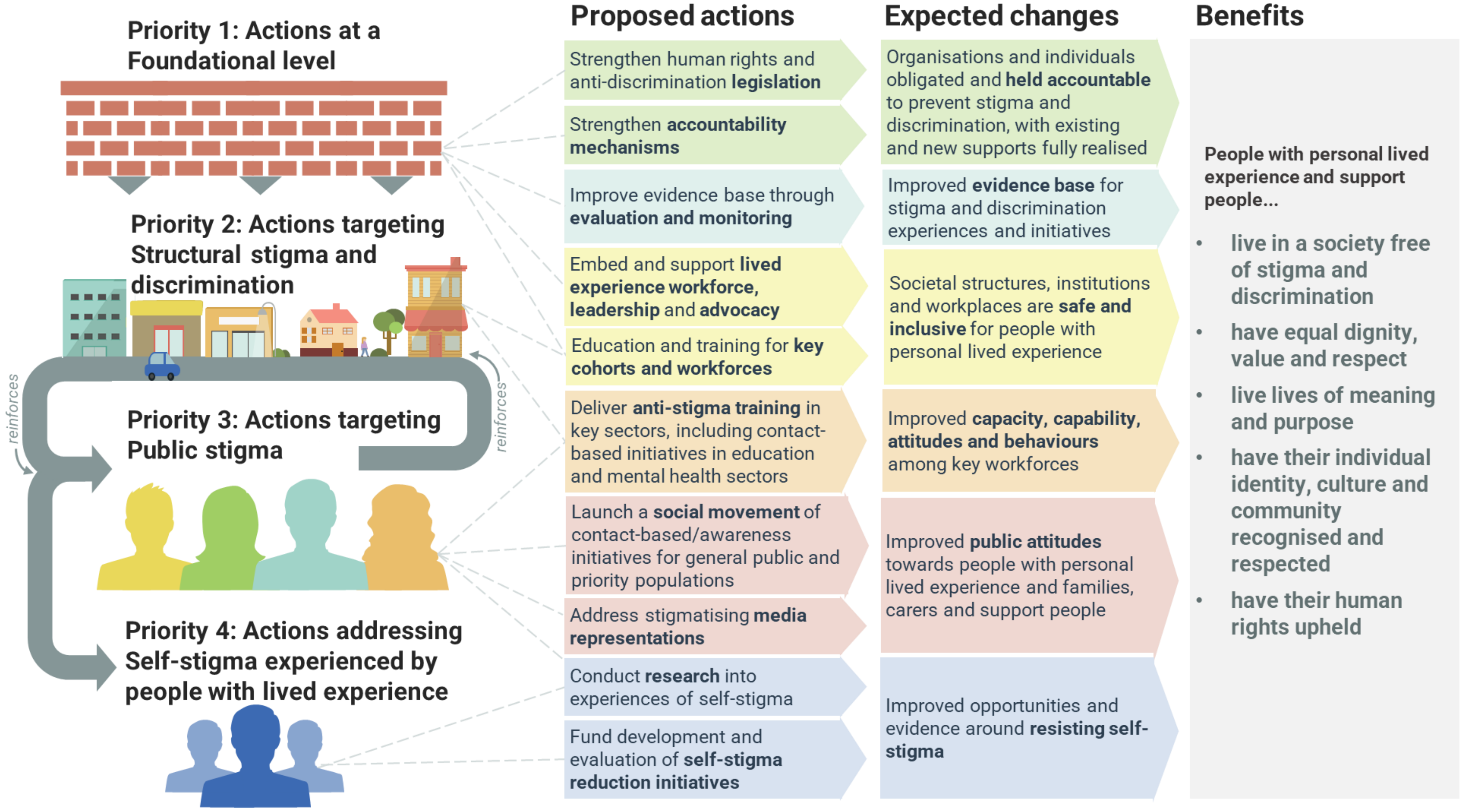
These priorities are supported by actions to implement objectives, including timeframes for implementation, who is responsible and indicators of change

How to create change

The below diagram shows how the actions in this (Draft) Strategy would work together to create change, and ultimately benefit the lives of people with personal lived experience and their families and support people. Types of stigma and discrimination (structural, public and self-stigma) are highly interrelated and actions in one area can generate benefits in another. As discussed in *Priority 1: Implement foundational actions to address stigma and discrimination*, foundational actions underpin actions at all other levels.

A number of foundational actions sit across the (Draft) Strategy priorities as presented in the diagram below. These sit across all settings and include:

- changing attitudes and behaviours of the public
- embedding lived experience in decision-making, advocacy and workforces
- embedding a rights-based approach with effective accountability mechanisms
- educating and training key cohorts and workforces to build their capacity to deliver critical services free from stigma and discrimination
- improving the evidence base through evaluation and monitoring.



Priority 1: Actions at a Foundational level

Priority 2: Actions targeting Structural stigma and discrimination

Priority 3: Actions targeting Public stigma

Priority 4: Actions addressing Self-stigma experienced by people with lived experience

Proposed actions	Expected changes
Strengthen human rights and anti-discrimination **legislation**	Organisations and individuals obligated and **held accountable** to prevent stigma and discrimination, with existing and new supports fully realised
Strengthen **accountability mechanisms**	
Improve evidence base through **evaluation and monitoring**	Improved **evidence base** for stigma and discrimination experiences and initiatives
Embed and support **lived experience workforce, leadership** and **advocacy**	Societal structures, institutions and workplaces are **safe and inclusive** for people with personal lived experience
Education and training for **key cohorts and workforces**	
Deliver **anti-stigma training** in key sectors, including contact-based initiatives in education and mental health sectors	Improved **capacity, capability, attitudes and behaviours** among key workforces
Launch a **social movement** of contact-based/awareness initiatives for general public and priority populations	Improved **public attitudes** towards people with personal lived experience and families, carers and support people
Address stigmatising **media representations**	
Conduct **research** into experiences of self-stigma	Improved opportunities and evidence around **resisting self-stigma**
Fund development and evaluation of **self-stigma reduction initiatives**	

Benefits

People with personal lived experience and support people...

- **live in a society free of stigma and discrimination**
- **have equal dignity, value and respect**
- **live lives of meaning and purpose**
- **have their individual identity, culture and community recognised and respected**
- **have their human rights upheld**

Priority 1: Implement foundational actions to address stigma and discrimination

To eliminate stigma and discrimination from Australian society and institutions, foundational systemic changes are first needed. Actions at this level are prerequisites for far-reaching change and enable the success of other actions across all other settings of society.

1.1 Strengthen human rights and anti-discrimination legislation

Australia is party to international human rights treaties that protect the human rights of people with personal lived experience (including the *United Nations Convention on the Rights of Persons with Disabilities*, the *International Covenant on Economic, Social and Cultural Rights*, the *International Covenant on Civil and Political Rights* and the *Convention Against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment or Punishment*). Various pieces of anti-discrimination legislation exist at the federal, state and territory level and form the 'foundation stone of human rights protection in Australia' but have been identified by the Australian Human Commission as in need of substantial reform. [33] In addition, in the absence of a Federal Australian Human Rights Charter, human rights have not been comprehensively codified into Australian federal law. There is a need for comprehensive, nationwide implementation of Australia's human rights obligations, both in general and specifically in relation to people with personal lived experience.

Strengthen protections through existing legislation

There is opportunity to introduce more consistent approaches and specific guidance in relation to legislative protection against mental health-related discrimination. There is also a need for educative materials for people who administer and interpret these laws (including the judiciary, insurers and employers), as well as for people with personal lived experience and their families and support people, to raise awareness around the availability of protections under these laws.

While 'mental illness' is included in the protected category of 'disability' (for example, under the *Disability Discrimination Act 1992* (Cth)), the extent to which it applies along the full spectrum between wellness and distress, mental ill-health and mental illness is unclear. There is also a patchwork of legislation and regulatory arrangements across states and territories, leading to potential inconsistencies of experiences and outcomes. Furthermore, the term 'disability' does not resonate for many people with personal lived experience, or their support people, which may limit the full use and uptake of the protections and entitlements that are available.

Potential areas for strengthening protections against mental health-related discrimination include:

- exploring the introduction of vilification protections explicitly outlawing mental health-related vilification. Similar protections exist under ACT legislation,[34] but are not present nationwide.

- clarifying the extent of protection afforded by the protected category of 'disability' in relation to 'mental ill-health' (as opposed to 'mental illness') and exploring mechanisms for achieving a nationally consistent approach to the application of protection on this basis[35,36]

- exploring options to ensure adequate provisions for people experiencing intersectional discrimination[37,38]

- addressing current reliance of legislative frameworks on an individual complaints model that redresses private harms, so that processes better enable systemic change[39]

- simplifying arrangements for establishing legislative components of unlawful direct or indirect discrimination, and strengthening protections around the duty to make ‘reasonable adjustments’[40,41,a]
- removing the 'other relevant factors' and ‘unjustifiable hardship’ tests from the insurance exemption under s46 of the *Disability Discrimination Act 1992* (Cth), on basis that such provisions have not been applied in practice and are too vague to justify the exclusion of protection under a human right.[42]

Mental health legislation, which varies between states and territories, is discussed further in *2.1 Require the mental health system to provide safe and empowering environments for people seeking services*.

Introduce a Federal Human Rights Charter

A Federal Human Rights Charter would ensure that human rights are built into the creation and interpretation of federal law. A Federal Charter would benefit people with lived experience by embedding protections such as equality before the law, privacy, and protections against arbitrary detention and cruel treatment. It could also protect and promote economic, social and cultural rights, including the right to health, the right to social security and the right to work, and provide support for actions to reduce structural stigma (see *Priority 2: Reduce structural stigma and discrimination*, below). Like state and territory models, a Federal Charter would create obligations for public authorities to consider human rights when making decisions, and to act in compliance with human rights, and would provide avenues for individual redress in cases of alleged breaches.

State and territory Human Rights Acts currently exist in Victoria, Queensland and the ACT. These Acts enshrine human rights into law, requiring individuals and institutions to interpret and apply laws in a way that is compatible with human rights. The operation of each Act is based on a ‘dialogue’ model, where there is an interaction between court decisions on human rights-based complaints and parliamentary responses. An example of the impact of Human Rights Acts is the contribution of the Victorian *Charter of Human Rights and Responsibilities Act 2006* (Victorian Charter) to a landmark judgment that found that a human rights-based approach must be embedded into decision-making in compulsory treatment cases.[b] The Victorian Charter ultimately resulted in some degree of systemic change in Victoria, and contributed to a human rights-respecting culture with the potential to prevent future human rights violations.[43]

The development of a Federal Charter would build on work by the Australian Human Rights Commission, which is advocating for consideration of a Federal Charter, alongside reforms to federal discrimination laws.[44]

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[a] Since 2017, people alleging discrimination because of a refusal to make a reasonable adjustment must establish both a) that the refusal disadvantages them and b) that the refusal is because of their disability. The second element places a difficult legal burden on the person seeking a reasonable adjustment to present causal evidence that the failure to provide reasonable adjustments is because of disability discrimination. See *Sklavos v Australasian College of Dermatologists* [2017] 347 ALR 78; FCAFC 128.

[b] This has ensured that the human rights of people with mental health issues must in future be taken into account by health professionals, the Victorian Civil and Administrative Tribunal, and the Mental Health Tribunal in relation to compulsory treatment. See *PBU & NJE v Mental Health Tribunal [2018] VSC 564 (1 November 2018)*.

1.2 Strengthen accountability mechanisms

Equitable complaints processes, expanded systematic independent scrutiny and transparent and regular reporting (see also *1.5 Improve the evidence base through data collection and evaluation*, below) are how Australian institutions are held to account for engaging in discrimination.

People affected by discrimination have access to a range of mechanisms to seek redress. These include formal and informal complaints processes, conciliation and court proceedings. However, these processes don't always involve reasonable supports for people with lived experience, and can be complex, costly (both financially and emotionally) and time-consuming, particularly where these systems are under-resourced compared to the number of complaints that are made.

More accessible avenues for complaint

Anti-discrimination complaints mechanisms that are overly complex or costly are not universally accessible and can lead to under-reporting of stigma and discrimination.[45] Substantial personal and legal costs generated by legal or complaints processes can restrict access to legal services for those who require assistance to seek legal redress (such as those with personal lived experience, low income, and/or other types of intersecting disadvantage).[46] There is a need to expand the supports available to ensure equitable access to these mechanisms.

Widely available and affordable advocacy or legal assistance is a precondition for complaints mechanisms to achieve accountability in a comprehensive and equitable way. Aside from providing expertise and representation to redress discrimination, advocacy and legal assistance services that are experienced in working with mental health-related stigma and discrimination cases are an important and accessible form of support which can minimise the risk of re-traumatising experiences in dealing with the legal system.[47] [47]

Ensuring equitable access to complaints processes also needs to include embedding disability supports and expertise throughout the system, as well as ensuring relevant information is communicated clearly and available through a range of communication mediums.

Increased independent scrutiny

A complaints-based system has the capacity to redress private and individual harms, however it is only in rare circumstances that this leads to broader systemic change that genuinely tackles underlying discriminatory conditions or stigma. There is limited independent or systematic scrutiny in place to proactively identify or eliminate instances of discrimination or to ensure that changes are implemented in response to complaints.

While complaints mechanisms are an important avenue for justice, total reliance on them to achieve accountability places a substantial and stressful burden on the people who have experienced unlawful and discriminatory behaviour. Consultation with people with personal lived experience and other experts indicates the importance of an independent body to identify and investigate discrimination complaints.[48]

Both existing and new anti-discrimination legislation must be enforceable through means other than complaints-based mechanisms. The presence of independent observers with powers to mandate changes to discriminatory conditions could play an important role in reducing the incidence of harm.[49,50]

1.3 Embed lived experience leadership and advocacy

The *United Nations Convention on the Rights of Persons with Disabilities*, to which Australia has been a signatory since 2009, states that people with lived experience shall be consulted and actively engaged in developing legislation and policies that concern people with disability. More work is needed to strengthen the role of lived experience leadership in Australia, particularly in embedding lived experience further in decision-making or advisory roles and in sectors where they have not traditionally had a presence, to help lead transformations of mindsets, culture, and practice.[51,52,53] Lived experience leadership involvement can also be valuable in individual advocacy (e.g. in health service complaints processes), although the extent to which this currently occurs varies across systems and jurisdictions.

Enhance lived experience opportunities from leadership down

Embedding lived experience leadership and representation into organisations carries a myriad of benefits, for people with personal lived experience, for the organisation, and for the wider community. The Lived Experience workforce intersects with lived experience workforces in the suicide prevention and alcohol and other drugs service landscapes. Some progress has been made in embedding lived experience roles, particularly in the mental health sector, where engagement with people with personal lived experience is a priority for health service accreditation. Some mental health organisations now feature lived experience roles within senior leadership.[54]

Embedding lived experience into governance and leadership is key to addressing structural stigma. Increasing visibility and engagement of the lived experience workforce can also reduce public stigma and self-stigma, promoting awareness that people can live fulfilling and contributing lives with and without personal lived experience.

Lived experience opportunities, especially in leadership, should actively involve wide and diverse cohorts rather than being limited to a small number of prominent individuals. This will achieve the dual benefits of encompassing more diverse perspectives, as well as avoiding the overburdening of existing lived experience workers. They should also expand beyond business settings to take in community settings, particularly where it is important to reinforce cultural safety. Effective means of responding to intersectional experiences in stigma and discrimination would involve implementing anti-stigma education programs in Aboriginal and Torres Strait Islander communities that are collaboratively designed, led and delivered by Aboriginal and Torres Strait Islander people with lived experience from those communities.[55,56]

Develop supports around Lived Experience workforce

Lived Experience roles enable the breaking down of stigma and stereotypes, creation of safe spaces for community conversations, and promotion of human empathy, connection, recovery, and hope. However, because the evidence base is still being established around the ongoing impact of relying on individuals with lived experience to perform advocacy, guidance, and leadership roles, it is a priority that support structures are built up around this workforce.

Safe and mentally healthy workplaces with effective accountability mechanisms are critical enablers for designated Lived Experience roles, and other employees with personal lived experience. The onus lies on the employer to prevent experiences of stigma and discrimination within the workplace in the first instance. Creating a safe workplace benefits not only employees with personal lived experience, but the wellbeing of all employees (see *2.6 Build equitable and supportive pathways into and within employment*). In addition, employers should provide and promote workplace policies that support Lived Experience employees to remain in their roles (such as stay-at-work plans).

Consultation with people in Lived Experience roles indicates problems with how their roles may be stigmatised by others within organisations, including systemic inequity in pay and career progression.[57] Guidelines for Lived Experience roles therefore recommend whole-of-workforce education and the fostering of support networks of allies and advocates, particularly at leadership levels, to promote understanding and acceptance of Lived Experience workforce roles as having inherent value.[58] Lived Experience workers, like all employees, should be made aware of their rights under anti-discrimination law and provided with effective avenues to make complaints in the event these are not upheld.

Increase access to lived experience advocacy organisations

Advocacy organisations play an important role in civil society to represent and redress power imbalances for members of their constituencies. The importance of lived experience advocacy organisations is well-known, but coverage of advocacy organisations is uneven across Australia. This means some people with personal lived experience across Australia may have little to no access to advocacy, entrenching their vulnerability to the harm caused by stigma and discrimination.

Consultations indicated the need to adequately fund lived experience advocacy organisations, both large and small, and to involve these organisations in strategy development and implementation. In 2019, the lack of a national consumer organisation saw the state consumer peaks form the National Mental Health Consumer Peak Alliance. Advocacy organisations add substantial value in offering expertise gained through lived experience, with good practice nationwide being separate peak bodies for personal lived experience and lived experience as a carer or support person. It is important that these bodies feature diverse perspectives from a broad range of people with lived experience.

1.4 Educate and train key cohorts and workforces

People with personal lived experience commonly report stigma and discrimination from those who are closest to them – friends, family members, colleagues and employers – as well as from professionals in the health and mental health systems. However, unfair treatment at an interpersonal level is also reported from people working across a range of other services and settings. There are also higher proportions of people who endorse stigmatising beliefs among certain cohorts in the community, including males, younger people, and people from culturally and linguistically diverse backgrounds.[59]

Education and training is critical to reducing stigma and discrimination from these sources. However, such initiatives need to go beyond general mental health literacy and awareness, to incorporate evidence-based approaches such as contact-based initiatives, to develop shared experiences and common understandings around mental ill-health. Training needs to be tailored to different cohorts and different settings, to develop skills and provide practical guidance on role-specific actions and behaviours to reduce stigma in relation to mental ill-health. It also needs to involve an appropriate level of nuance and detail to distinguish between different types of experiences of mental ill-health, including those experienced by people with complex mental health need. There is also a role for supporting the development of reflective practice amongst professionals.

For workforces, stigma and discrimination should be embedded within existing education and training approaches, including in pre-service training, staff onboarding and ongoing professional development. Importantly, this (Draft) Strategy also acknowledges that responsibility for workforce training does not sit solely with individual workers. Effective implementation also relies on the availability of sufficient resources – both funding as well as time for workers to undertake training – as well as practical considerations at the level of workplaces and industries, such as job design, standard practices and workplace cultures.

Specific actions around education and training are included throughout this (Draft) Strategy, including for different workforces across service settings explored under *Priority 2: Reduce structural stigma and discrimination* as well as other actions around attitudes held by members of the public under *Priority 3: Reduce public stigma*.

1.5 Improve the evidence base through data collection and evaluation

Currently, there is a gap in evidence relating to mental health-related structural discrimination.[60] Likewise, there is a need for an a more solutions-focused evidence base, based on evaluation and monitoring of stigma-reduction initiatives.[61]

Understanding experiences of stigma and discrimination through regular data collection

More regular collection of population-level data measuring the prevalence and experiences of mental health-related stigma and discrimination in Australia is urgently required. This is particularly true of structural stigma and self-stigma, which are understudied; intersectional and cross-cultural experiences; and the experiences of people with alcohol and other drug issues.

More regular and more granular collection of information about people's experiences, both qualitative and quantitative, would support improved understandings of and responses to diverse lived experiences. It would also reduce the likelihood of broad-brush assumptions, ultimately building a more robust evidence base. Qualitative research is an important complement to survey-based data, to generate deeper insights into people's experiences of stigma across diverse contexts. Qualitative research also allows for more nuancing of language to engage with different conceptualisations of mental health across and within communities.

Robust approaches to population-based data collection should be adopted. These include repeated cross-sectional surveys to allow the study of stigma and discrimination over time, consistent use of a probability-based sampling procedure, mixed-methods survey approach, and validated measurement tools.[c] [62] People with personal lived experience should be involved in the selection and design of tools, and consideration given to which measures have been used in previous Australian studies (to enabling observation of change over time). The BETA team in the Department of the Prime Minister and Cabinet developed a baseline survey to support the development of this (Draft) Strategy. There is an opportunity to build on and repeat this survey over time, in partnership with the Commission, or with existing data stewards including the Australian Institute of Health and Welfare.

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[c] For instance, the Depression Stigma Scale or the Social Distance Scale to measure public stigma, the Internalized Stigma of Mental Illness Scale or the Self-Stigma of Mental Illness Scale to measure self-stigma, the Discrimination and Stigma Scale to measure discrimination. Additionally, specific mental ill-health terms or vignettes should be used rather than non-specific mental illness terms.

Monitoring and evaluating implementation of stigma reduction initiatives

Significant gaps exist in the evaluation of stigma reduction initiatives, which is a key factor in building the evidence base. Little evaluatory evidence is available on the effectiveness of legislation or regulations for reducing discrimination of people with depression, anxiety or suicidality, or for measures to reduce discrimination against people with more complex mental health needs, such as those diagnosed with schizophrenia or personality disorders.[63]

More specific collection of information about use and outcomes of complaints mechanisms is needed. Across different sectors, a patchwork of complaints mechanisms is present with varying powers; however, collation of these complaints usage and outcome data does not occur at a cross-sector or national level. This results in difficulty in evaluating the effectiveness of complaints mechanisms or the barriers and enablers of anti-discrimination legislation, or to draw learnings from these.[64]

Monitoring and evaluation of the implementation of stigma reduction initiatives (including any implemented in response to this (Draft) Strategy) should adopt a mixed-methods approach to understand the barriers and enablers of population-level impacts. An implementation science framework, such as the RE-AIM framework[d], is a best practice monitoring and evaluation technique, given that it allows for the public health impact of Strategy components to be monitored at both individual and institutional levels.[62] Monitoring should also draw from relevant existing and in-development data collections, including administrative data and policy implementation/evaluation frameworks.[e] Consideration should also be given to opportunities to build upon these collections to ensure a level of granularity around different experiences of mental ill-health and stigma and discrimination.

Further, it will be critical to establish targets which speak not only to the discriminatory behaviours we want to reduce, but the positive and inclusive behaviours we want to see more of.

Priority foundational actions

Priority actions to address stigma and discrimination at the foundational level are listed in the table below.

Ref	Action	Timeframe	Who's responsible	Expected changes
1a	Conduct scoping for a national independent function to: • collect national consolidated usage and outcomes data on discrimination complaints relating to mental ill-health under federal, state and territory legislation • coordinate with other complaints and investigation bodies (including at	Short term	Australian, state and territory governments	Recommendations made and acted upon to increase transparency around mental health-related complaints

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[d] The RE-AIM evaluation framework measures reach, effectiveness, adoption, implementation and maintenance of interventions, and has primarily been used in evaluation of public health interventions.

[e] For example, Australia's Disability Strategy 2021-2031: Outcomes Framework and current development work around the National Disability Data Asset. [62]

Ref	Action	Timeframe	Who's responsible	Expected changes
	state/territory level) to monitor other mental ill-health-related complaints - identify and provide advice to governments on emerging systemic issues in relation to unfair treatment and discrimination on the basis of mental ill-health			
1b	Review work to date through the Australian Human Rights Commission's *Free & Equal* project, and collaborate on next steps, with a view to ensuring strengthened human rights and anti-discrimination protections for people with personal lived experience, and their families, carers and support people. This should include consideration of: - vilification protections - guidance around the extent of protection afforded by the protected category of 'disability' in relation to mental ill-health - considerations around introducing a new protected category for mental ill-health and suicide - ensuring adequate provisions for people experiencing intersectional discrimination - simplifying arrangements for establishing legislative components of unlawful direct or indirect discrimination, and strengthening protections around the duty to make 'reasonable adjustments' - the adequacy of operational resourcing for complaints resolution and systemic analyses around complaints mental ill-health related complaints	Short term	Australian Government	Work to strengthen human rights and anti-discrimination protections has a specific focus on mental ill-health, including recommendations to reduce stigma and discrimination at a population level and among priority populations and improve satisfaction of complaints processes
1c	Progress scoping for a National Human Rights Charter which aligns with and enshrines into law Australia's obligations under international human rights law, in partnership with Australian Human Rights Commission, in consultation with people with	Medium term	Australian Government Australian Human Rights Commission	Work to develop a National Human Rights charter has a specific focus on engagement with people with personal lived experience of

Ref	Action	Timeframe	Who's responsible	Expected changes
	personal lived experience (including priority populations)			mental ill-health and those who support them
1d	Establish peak body arrangements that recognise, support and amplify the separate and distinct advocacy needs of people with personal lived experience and of families, carers and support people.	Medium term	Australian Government	Establishment of national representative bodies
1e	Conduct population-level research to collect qualitative and quantitative data on prevalence and experience of: • public stigma • structural stigma and discrimination, including in health, mental health, social services, financial, legal, employment, and education sectors • self-stigma among people with personal lived experience and support people Repeat data collection regularly, incorporated into future National Surveys of Mental Health and Wellbeing or similar data collection mechanisms Use repeated cross-sectional surveys using the same sampling procedure (probability-based sampling), survey mode (mixed-mode surveys) and reliable stigma measurement tools Collect longitudinal data on stigma and discrimination among priority populations (Aboriginal and Torres Strait Islander people, LGBTIQA+, people with complex mental health needs, people with co-occurring conditions)	Medium term	National Mental Health Commission Australian Bureau of Statistics Australian Institute of Health and Welfare Behavioural Economics Team of the Australian Government (BETA)	Increased quantitative prevalence data and qualitative experience data for: • people with personal lived experience at a population level • people with personal lived experience from priority populations
1f	Fund services across all states and territories which provide legal assistance for people with personal lived experience in navigating complaints processes and the legal system	Medium term	Australian, state and territory governments	Increased number of people making discrimination complaints who have access to legal assistance or pro bono legal representation

Ref	Action	Timeframe	Who's responsible	Expected changes
1g	Develop guidelines for Lived Experience workforce roles in sectors outside the mental health system, leveraging guidelines in development in some sectors	Medium term	National Mental Health Commission	Guidelines developed Increased number of Lived Experience workforce roles and leadership roles available
1h	Commence scoping and socialisation for a program to scale up the Lived Experience workforce through national capacity building and workforce promotion	Medium term	National Mental Health Commission	Recommendations made and action taken toward developing a program to increase number of Lived Experience workforce roles and leadership roles available
1i	Routinely collect data on the number of Lived Experience workforce roles and leadership roles filled and opportunities available	Medium term	National Mental Health Commission	Increased data on the number of Lived Experience workforce roles
1j	Monitor and evaluate the implementation of stigma reduction initiatives, through a mixed-methods approach and using an implementation science framework (e.g. RE-AIM)	Medium term	National Mental Health Commission	Increased evidence about effectiveness for stigma reduction initiatives, generated by evaluation

Priority 2: Reduce structural stigma and discrimination

Traditionally, research and interventions addressing mental health-related stigma and discrimination have focussed on changing the attitudes, perceptions, and behaviours of individuals. More recently, there have been calls for a greater focus on tackling structural stigma and discrimination through systemic change.

There is abundant evidence that mental health-related stigma and discrimination are entrenched in many, if not most, of Australia's institutions and societal structures.[65] Where there are inherent power imbalances between a person and the institutions and structures they interact with (such as those that have control over the person's access to employment, education, healthcare, housing or other life domains) stigma towards people with personal lived experience can be consciously or unconsciously enacted to reinforce an unjust social order.[66] Unjust social orders based on stigma and discrimination negatively impact on people's life opportunities.

Recognition of unjust social orders reflects the social model of disability.[67] The social model of disability describes how the barriers located in the environment (elements of physical, social, policy or legal environments) can prevent full participation in society. Structural stigma and discrimination involve the denial of opportunity based on broad categories, including current or past experience of mental ill-health. It may also be seen when broad restrictions are imposed on a person, rather than constraints on specific activities for a period of time, and based on individual need.

Structural stigma is when laws, policies, practices and organisational structures enable unfair treatment of people who experience mental ill-health.[68] This includes where it is much harder for people who experience mental ill-health to access vital services and to participate in society.

Discrimination occurs when a person or group of people, is treated less favourably (direct discrimination), or when an unreasonable rule or policy disadvantages some people because of a characteristic they share (indirect discrimination). Discrimination can be against the law if it is based on a protected attribute or characteristic, such as disability, and occurs in certain areas of public life, such as employment and education.

This priority seeks to address these structural barriers within seven key settings:

- mental health system
- health system
- social services
- financial services and insurance
- legal systems
- employment
- education and training.

Evidence suggests that these are the settings in which stigma and discrimination are most frequently or significantly experienced by people with personal lived experience and their social supports. Structural change in these settings needs to sit alongside social change, discussed further in *Priority 3: Reduce Public Stigma*.

2.1 Require the mental health system to provide safe and empowering environments for people seeking services

There is well-documented evidence about people's experience of stigma and discrimination in the mental health system. These experiences undermine treatment and reduce the likelihood of successful mental health outcomes, which can worsen discrimination in other settings. A mental health system that is free from stigma and discrimination provides time and space for people to tell their story, doesn't judge or make assumptions based on someone's diagnosis or background, and empowers people with personal lived experience to make choices about their own care.

Delivering culturally safe care

A significant number of people from culturally and linguistically diverse backgrounds do not seek support for their mental health or are reluctant to do so due to experiences of stigma and/or discrimination. Barriers to access include greater mental health-related stigma in some culturally and linguistically diverse communities, language barriers, cultural misunderstandings, experiences of racism in services and experiences of trauma.

Negative experiences in mental health services can result from a lack of understanding of cultural interpretations of mental health. For example, Aboriginal and Torres Strait Islander concepts of mental health can differ from other Australians. Experiences which may be seen as symptoms of mental health in non-Indigenous communities may be viewed differently in Aboriginal and Torres Strait Islander communities and vice versa.

Gaps in cultural knowledge and understanding can lead to misdiagnosis, delayed or inappropriate diagnoses. A lack of cultural competency can have a significant impact on cultural safety, resulting in lower rates of access to services and poor-quality care.[69] Language barriers can also hinder communication and accurate assessment.[70]

People from culturally and linguistically diverse backgrounds are over-represented in involuntary admissions and acute inpatient units, receive poorer quality of care than the majority of the population, and are at risk of errors and incidents leading to potentially serious clinical consequences.[71]

Providing culturally safe mental health services is vital to ensure meaningful care and improve mental health outcomes for people from diverse backgrounds and experiences. Cultural safety seeks to promote cultural integrity and the promotion of social justice, equity, and respect.[72] All care, support, and treatment should be trauma-informed and acknowledge the high prevalence of intergenerational trauma brought about by colonisation.

> *"Any work in this space must acknowledge the significant impact of trauma."*
>
> WORKSHOP PARTICIPANT

Culturally safe services should be community-led and take a holistic and whole-of-life approach, including kin and/or family where appropriate, in all aspects of care. Services should be tailored to the culturally and linguistically diverse community of interest and take into account different cultural explanatory modes of stigma and distress. Mainstream mental health services should learn from and partner with Aboriginal Community Controlled Organisations, which consider the social and emotional wellbeing needs of the whole person, in the context of their family and community.

Many of the initiatives that will help to reduce stigma and discrimination experienced by people from culturally and linguistically diverse backgrounds relate to the way in which mental health services are designed and delivered. There is a need for a unified, nationally consistent approach to addressing the mental health needs of people in these communities, that is co-designed and co-produced and includes tailored actions to reduce stigma and discrimination specifically related to mental ill-health, trauma and distress in these communities.

Eliminate restrictive practices

People with personal lived experience are at risk of being subject to coercive or restrictive approaches. Examples of such approaches include the use of excessive physical force, mechanical restraint, seclusion, coercion to take a particular treatment path, and use of medications as chemical restraint. These practices can also involve a lack of empathy, lack of communication and interaction, and lack of alternative strategies to the use of seclusion and restraint.

Restrictive practices have been recognised as a restriction on a person's rights.[73,74] Their elimination has been called for internationally through the work of the United Nations, including by the former United Nations Special Rapporteur on Torture and the United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee).[75] Experiences of coercive and restrictive practices can be inherently traumatising and can result in emotional and physical harm for people receiving care, support people, and the workforce. These practices also reinforce the stigma and public fear that surround mental health, perpetuating the message that if a person needs acute psychiatric care, they'll be 'locked up' or punished, rather than treated with dignity and respect.[76] In addition to the harms experienced by consumers, the workforce can suffer moral distress when involved in the use of seclusion and restraint.

Health professionals and people with personal lived experience agree that the use of seclusion and restraint is detrimental to the therapeutic relationship required to support effective care, support, and treatment.[77] Factors have been identified as contributing to the use of these practices, including organisational culture, the physical environment, under-resourced mental health services, challenges in implementing person-centred care, and fear and unwarranted negative attitudes.[78]

All Australian governments are working towards the reduction of, if not the elimination of, the use of seclusion and restraint.[79] However, despite a commitment exceeding 15 years, and further support from the Royal Australian and New Zealand College of Psychiatrists, and the Royal Commission into Victoria's Mental Health System, as well as focussed work towards improvement,[80,81] these practices persist.[82]

> *"[Autonomy and agency] feel life giving and changing. Getting through moments of discomfort and makes me feel more alive and connected, more integrated as a person."*
>
> WORKSHOP PARTICIPANT

All mental health services require policies, resources, and frameworks in place to work toward the elimination of restrictive practices. Such policies should clearly outline the specific and limited circumstances in which seclusion and restraint may be considered during the transition towards elimination. Oversight and accountability mechanisms that regulate the use of seclusion and restraint are required to ensure complaints and breaches receive effective responses.

Promoting rights of people with personal lived experience

The power differential between people accessing mental health services and the professionals who deliver those services has a long history and is integral to structural discrimination. People seeking help are in a position in which they must trust in the knowledge and guidance of the professional. This results in vulnerability and means that people are susceptible to harm through misuses of power and influence. Ensuring that people's human rights are upheld while seeking access to mental health services is critical to the prevention of discriminatory practices in the mental health system.

Introducing stronger legislative provisions that not only protect from discrimination within mental health services, but that do more to promote the rights of people accessing mental health, will act to correct the power imbalance and empower people to make choices about their care. This could include better aligning Australia's mental health legislation with the Convention on the Rights of Persons with Disabilities and international best practice human rights legislation.

Formalising and embedding supported decision-making processes and advance care directives give voice to a person's wishes and empower others, including families, friends, unpaid carers and support people, and ensure those wishes are followed.

Valuing lived experience expertise in the mental health workforce

It is not just those accessing mental health services who face stigma and discrimination. The lived experience workforce can encounter stigma and discrimination, particularly those in designated lived experience roles. The Royal Commission into Victoria's Mental Health System heard testimony from witnesses who described "encountering negative beliefs about the capabilities of lived experience workers". The Commission heard of "people living with mental illness described and treated in demeaning ways, being made to feel less capable than other staff, being paid less than others for commensurate roles, and being denied opportunities for career progression".[83]

A recent study sought to investigate the experiences of lived experience workers employed in mental health services, with a particular focus on their experiences of safety and discrimination. The study found that the majority of participants felt they were treated differently based on their position as a lived experience worker, with more than one third reporting that their employment conditions were less favourable than their colleagues without personal lived experience. More than half of respondents agreed with the statement "I feel that others in the workplace make judgements about me based on my disclosed lived experience". The report noted the widespread undervaluing of lived experience perspectives, the dominance of the medical model,[f] [84] [85] and the strong hierarchy and power imbalance in the mental health workforce in which Lived Experience workers occupied the lowest level.[86]

The lived experience workforce is a critical resource in addressing stigma and discrimination within mental health services and should be accorded the appropriate recognition. Lived experience workers can promote and enact change within the services in which they're employed. Regardless of their job position, each worker is a 'change agent' – acting to facilitate cultural and practice change in services.

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[f] The 'medical model' is a biopsychosocial approach whereby a health professional assesses a person's problems and matches them to a diagnosis or classifications, for which treatments are identified.

Recent efforts have been made to address structural stigma and discrimination in the mental health system, particularly in relation to increasing the employment of, and support for, people with lived or living experience. In line with an action outlined in the Fifth National Mental Health and Suicide Prevention Plan 2017-2022,[87] the Commission led the development of the *Lived Experience (Peer) Workforce Development Guidelines*.[88] Recognising that a thriving mental health Lived Experience workforce is a vital component of quality recovery-focused mental health services, the Guidelines are part of a suite of materials that create a single overarching framework for the development of the lived experience workforce. They are intended to inform decision makers, including employers and funding bodies, and support change across the mental health sector by improving understanding of the benefits of the Lived Experience workforce and by supporting employers to assess their local readiness and prioritise activities that support successful implementation.[89]

Better recognising the value of peer work and the utilisation of lived experience expertise in mental health service provision, including aligning pay and professional standards with the broader health workforce, would support this workforce to act as critical agents of change in ensuring that mental health services are stigma-free environments. This could include incorporating lived experience leadership in all models of care, settings and at all levels across the mental health system. It also could include a more diverse and representative mental health workforce, including people with different experiences of mental ill-health and from different cultural backgrounds.[90,91] Finally, more could be done to support mental health professionals to disclose their own personal lived experience, for example through revising professional standards, adjusting processes, or incentivising disclosure where it is relevant to the therapeutic process.

Priority actions for the mental health system

Priority actions to enable the mental health system to provide safe and empowering environments for people seeking services are listed in the table below.

See also, *Stigma reduction education for mental health professionals* and associated actions listed under *Priority 3: Reduce public stigma*, below.

Ref	Action	Timeframe	Who's responsible	Expected changes
2.1a	Ensure that every mental health service has a clear and accessible policy on the use of seclusion and restraint, which aims to eliminate their use. This policy should be supported by resources, including staff training, on alternatives to the use of seclusion and restraint	Short term	State and territory governments and all mental health services	Reduction in use of seclusion and restraint with a goal of elimination
2.1b	Review existing cultural competence/safety frameworks relating to Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse (CALD) backgrounds. Resources should explore barriers to implementation and provide support for adoption	Short term	Australian, state and territory governments, National Mental Health Commission, organisations representing CALD and Aboriginal and Torres Strait	Increased cultural competence of mental health services, including mental health professional understanding of, and attitudes towards, Aboriginal and Torres Strait

Ref	Action	Timeframe	Who's responsible	Expected changes
			Islander organisations and communities, broader community	Islander people and people from CALD backgrounds
2.1c	Introduce accountability mechanisms, including a requirement for mainstream mental health services to form partnerships with their local Aboriginal Community Controlled Health Organisation(s) in order to provide culturally safe care to Aboriginal and Torres Strait Islander people	Medium term	Australian state and territory governments	Increased number of mainstream mental health services with formal partnerships with Aboriginal Community Controlled Health Organisations, and community-rated assessment of effectiveness of these partnerships
2.1d	Work with communities and sector organisations to co-design and co-produce a new national strategy for culturally and linguistically diverse community mental health and wellbeing, which includes a specific stigma-reduction focus.	Medium term	Australian, state and territory governments Organisations representing CALD communities	Development of national strategy for culturally and linguistically diverse community mental health and wellbeing
2.1e	Review and where necessary amend mental health legislation to promote and protect human rights, aligned with international human rights frameworks and obligations	Medium term	State and territory governments	State and territory mental health Acts reviewed and amended as required
2.1f	Take steps to increase and better support the Lived Experience workforce across all mental health services, in line with the *Lived Experience (Peer) Workforce Development Guidelines*. This should include employment of people with personal lived experience, and carers and support people, in peer support roles and in positions of leadership, as well as practical guidance for employers	Medium term	Mental health services	Increase in number of mental health services with Lived Experience workers employed in both service delivery and governance roles
2.1g	Establish a national professional association for lived experience workers, which could provide training,	Medium term	Australian Government	Establishment of national body with sufficient resources

Ref	Action	Timeframe	Who's responsible	Expected changes
	accreditation, support, and advocacy services			to support lived experience workers
2.1h	Strengthen oversight and accountability mechanisms regulating the use of seclusion and restraint to ensure complaints and breaches receive effective responses	Medium term	State and territory governments	Reduction in use of seclusion and restraint
2.1i	Work with mental health professional bodies to review professional standards and other relevant structures to provide guidance around mental health professionals disclosing their personal lived experience	Medium term	Australian Government Professional peak bodies (e.g. Australian Psychological Society)	Shifts in revised standards and structures
2.1j	Introduce legal mechanisms for supported decision-making and advance care directives in relation to people accessing mental health services.	Long term	State and territory governments	Number of states and territories with legal mechanisms available to consumers of mental health services

2.2 Ensure equity of access to quality healthcare

Although many people may seek and receive the healthcare they need from these services, people with a personal lived experience can experience unfairness and/or injustice when doing so, and often have poorer physical health than people who do not have this experience. People with a personal lived experience are likely to die between 14 and 23 years earlier than the general population.[92] A key factor is diagnostic overshadowing, where a person's physical health issues are not properly attended to by a healthcare professional due to a focus on their mental health issues.[93]

Structural elements of the health system, including the policies, procedures, and funding arrangements that underpin the system, reflect society's attitudes towards people with personal lived experience. Where structural stigma and discrimination exists, it can have the impact of physical health conditions not being accurately detected, diagnosed, or treated. It can also discourage help-seeking. This leads to lower levels of access and care and reduces the likelihood that people who are impacted by this will have positive health outcomes. This may, in turn, affect their experience of stigma and discrimination in other settings. Some groups, such as Aboriginal and Torres Strait Islander people, face multiple and intersecting challenges in accessing quality healthcare, including due to racial discrimination.

Addressing structural stigma and discrimination in healthcare settings would mean that people with personal lived experience would have access to the same range, quality, and standard of healthcare as everyone else. While initiatives such as *Equally Well* (see Box 1, below) are taking important steps towards equal access to quality health care for people with lived experiences, there are opportunities to boost traction and uptake.

Box 1: Spotlight on *Equally Well*

Work has already commenced to address stigma and discrimination in the health system. *Equally Well* is a collaboration of people and organisations working together to address the physical health disparities of people living with mental illness. In 2017, the Commission launched the Equally Well Consensus Statement. At the time of its launch, the Consensus Statement was signed by 53 organisations, including all state and territory governments, pledging their commitment to work together to improve the quality of life for people with personal lived experience by championing their equal access to quality health care, including through anti-stigma initiatives. Today, over around 100 organisations (including governments and government departments) have formally pledged their commitment to the Consensus Statement.

Structural stigma and discrimination manifests in the health system in two primary ways: access and quality.

Providing equitable access

Australians with mental health conditions can experience challenges navigating the health system. Those with personal lived experience are more likely to experience barriers to access to care, compared with the rest of the community.

'Access' describes the ability of a person to receive appropriate healthcare when and where they need it. Factors such as the adequate supply, cultural and physical safety, affordability and suitability of services all contribute to whether or not a service is accessible.[94] Barriers to access can also include the attitude and behaviour of health professionals towards people with personal lived experience.[95]

Inequitable access to healthcare can result in structural stigma. Those with personal lived experience can face structural stigma when policies and practices produce inequitable access to healthcare. Lack of equitable access to mental health care can result in the undertreatment of health problems, withholding of services, and fragmentation of care.[96]

Some of the ways that structural stigma and discrimination manifests in relation to access to the health system include:

- a significant power differential between the person with lived experience and the healthcare professional, and the stigmatising beliefs of the health professional, which manifests in the person feeling like they're being talked down to and infantilised. This can result in the person being denied their autonomy and independence to make their own decisions about their care. Sometimes, the role of power imbalances can be overlooked as they become the norm and are taken for granted.[97]

- the reduced life expectancy of people with multiple unmet mental health needs (e.g. people with a diagnosis of borderline personality disorder). This can be partially described by 'diagnostic overshadowing'.[98]

- the separation of mental health and alcohol and other drug services from broader health services. Despite the strong relationship between mental health, substance use and physical health, healthcare services for each of these issues are commonly provided in separate locations by different professionals. This artificial separation, and the lack of coordination between systems, limits the ability to provide ‘joined up’ or integrated care, where a person with multiple needs receives care in a coordinated way. [99]

Equity of access to healthcare service for people with personal lived experience can be improved by:

- strengthening the integration and coordination of care across mental health, physical health, and alcohol and other drug sectors, along with cultural care services, so that the provision of care considers a person’s holistic needs and is health-promoting
- shifting the power dynamic between health professionals and people with personal lived experience, as well as between health professionals and carers and supporters, recognising that the person is an expert in their own experience.

> *“[We need] a compassionate approach and structural changes to incentivise compassionate, whole-of-person care.”*
>
> WORKSHOP PARTICIPANT

Delivering quality care equitably

A consequence of structural stigma and discrimination is people with a personal lived experience being more likely to experience poorer quality of care, compared to people without this experience.

Healthcare professionals are agents of the healthcare system and, as such, key structural components of organisations and systems. When engaged in stigmatising practices, they are also the agents of structural stigma. Research indicates that structural stigma most commonly manifests in professional practices, including the unwritten procedures and practices of healthcare professionals.

Negative attitudes and poor practices among healthcare professionals is a primary driver of low-quality care. In a survey conducted in 2021, approximately 24 per cent of people with recent personal lived experience reported being treated unfairly by a health professional when getting help for a physical health problem. Other experiences include the healthcare professional not believing that the problem was real or needed treatment, not being willing to listen, not being supportive or caring, lacking understanding of mental health, ignoring physical health problems, not treating with appropriate medication or avoiding the person altogether. There is evidence that GPs have higher stigmatising attitudes than professionals with training specifically in mental health disciplines.[100,101]

People with experience of discrimination are also more likely to visit hospital or specialist doctors than those who experienced positive, supportive environments. It found that people in supportive environments were more likely to visit mental health professionals in a primary care setting and were therefore less likely to receive hospital treatment. These findings indicate that people with personal lived experience in supportive, rather than discriminatory, environments may be more willing to seek out earlier treatment for their mental health challenges.[102] Receiving earlier support for mental health issues can have significant and life-changing consequences for a person’s mental health.[103]

> *“[The best thing is] just sitting with someone, being present, human connection. We have two ears and only one mouth – listening to a person is healing.”*

WORKSHOP PARTICIPANT

Research has indicated that the quality of healthcare provided to people with personal lived experience can be improved through altering incentives and building the skills and capacity of the health workforce, including first responders, to support them to:

- build trusting and ongoing relationships
- engage in shared decision-making
- provide trauma-informed care
- understand the interplay between physical health and mental health
- understand the effects of diagnostic overshadowing.

Further, quality can be enhanced through employing people with personal lived experience within healthcare organisations as peer support workers, peer navigators, advocates and facilitators of anti-stigma programs, as well as in positions with meaningful influence regarding healthcare governance, policy design, program implementation and evaluation.

> *“Health professionals need to talk more about their own experiences and vulnerabilities to combat the belief that they need to be infallible. We need to break down the division between ‘us’ and ‘them’.”*

WORKSHOP PARTICIPANT

Box 2: Spotlight on the Fifth National Mental Health and Suicide Prevention Plan

Action 19 of the Fifth National Mental Health and Suicide Prevention Plan 2017-2022[3] is for governments to reduce stigma and discrimination in the health workforce by:

- developing and implementing training programs that build awareness of and knowledge about the impact of stigma and discrimination
- responding proactively and providing leadership when stigma or discrimination is seen
- empowering consumers and carers to speak about the impacts of stigma and discrimination.

To support the implementation of this action, the Australian Government has committed:

- $1 million in the 2021-22 Budget for initiatives to reduce the stigma associated with mental health among health practitioners and promote mental health as a preferred career option
- $409,000 in the 2022-23 Budget for stigma reduction and career promotion activities to encourage students to choose a career in mental health. This is part of a $60.7 million investment to implement the National Mental Health Workforce Strategy in the 2022-23 Budget.

Priority actions for the healthcare system

Priority actions to ensure equity of access to quality healthcare are listed in the table below.

Ref	Action	Timeframe	Who's responsible	Expected changes
2.2a	Renew the call for organisations to commit to the actions set out in the Equally Well Consensus Statement	Short term	National Mental Health Commission Equally Well Alliance	Increased number of organisations that pledge their commitment
2.2b	Ensure minimum standards/clinical guidelines are in place for the physical healthcare of people with personal lived experience, including for healthcare providers to collaborate with other relevant service providers to deliver holistic care	Short term	Australian Commission on Safety and Quality in Health Care	Minimum standards promulgated to health services with evidence they have been embedded in services
2.2c	Ensure minimum standards/clinical guidelines are in place for the care of co-occurring alcohol and other drug problems among people with personal lived experience, including for healthcare providers to collaborate with other relevant service providers to deliver holistic care	Short term	Australian Commission on Safety and Quality in Health Care	Minimum standards promulgated to health services with evidence they have been embedded in services
2.2d	Ensure guidelines for healthcare providers that set out approaches to delivering person-centred care, including approaches for empowering people receiving care, are in place and disseminated to health services	Short term	National Mental Health Commission	Guidelines promulgated to health services with evidence they have been embedded in services
2.2e	Promote the *Lived Experience (Peer) Workforce Development Guidelines* among health services to encourage the employment of people with personal lived experience or as a support person: • at all levels of the hierarchy, including in leadership positions • in Lived Experience roles that support people accessing the service to feel supported, advocate for their needs and navigate their care (particularly in emergency departments)	Short term	National Mental Health Commission	Increased proportion of mental health services with Lived Experience workers employed in both service delivery and governance roles
2.2f	Evaluate and report on the extent to which actions set out the Equally Well Consensus Statement have been	Medium term	Equally Well Alliance	Evidence of impact of Equally Well Consensus

Ref	Action	Timeframe	Who's responsible	Expected changes
	implemented, and their impact on reducing stigma and discrimination		National Mental Health Commission	
2.2g	Employ people with personal lived experience or support people in designated lived experience roles within government health departments, including in positions of leadership	Medium term	Australian, state and territory governments	Increased number of people with lived experience in health departments, including at executive levels
2.2h	Ensure funding guidelines for healthcare services: • do not unfairly exclude people with personal lived experience from receiving services • incentivise services to create safer, stigma-free environments, for example through including criteria related to demonstrating approaches taken to reduce stigma in funding application processes	Medium term	Australian, state and territory governments	Elimination of stigmatising or discriminatory provisions from funding guidelines
2.2i	Review Medicare arrangements to ensure that GPs are incentivised to provide high quality healthcare to people with personal lived experience	Long term	Australian Government	Enhanced experience of people with personal lived experience accessing healthcare from a GP
2.2j	Evaluate and report on initiatives to reduce stigma and discrimination in the health workforce	Medium term	National Mental Health Commission	Evidence of impact of stigma reduction initiatives informs ongoing efforts
2.2k	Develop and deliver, in collaboration with the Lived Experience workforce, ongoing professional development training for healthcare professionals that covers the following: • mental health and suicide prevention fundamentals • conceptions of mental health across different cultures • the interplay between mental health and physical health • person-centred care, including trust-building and shared decision-making • trauma-informed care	Long term	Relevant health regulatory bodies and professional associations	Increase in health professionals' understanding of mental health, and attitudes towards people with personal lived experience

Ref	Action	Timeframe	Who's responsible	Expected changes
	• the impacts of diagnostic over-shadowing • the therapeutic benefits of healthcare professionals who appropriately disclose their own personal lived experiences • human rights Workforces to be targeted include primary care, acute care and emergency care professionals.			

2.3 Ensure social services, including social security, disability supports, housing and child protection, are equitable and non-discriminatory

Social security, housing, disability and other social services are supports required by many people with personal lived experience to support their recovery. However, structural barriers present challenges for people with personal lived experience seeking access to these critical services. This is particularly the case for people with complex mental health needs and/or who experience intersecting forms of stigma and discrimination. The impact that having (or not having) access to these important supports has on wellbeing, social inclusion and other life opportunities means it is essential to ensure social services are equitable and non-discriminatory.

Eliminate barriers to accessing social services

People with personal lived experience, and their families and support people, may require social security payments because they either cannot work, or cannot secure enough income, due to the impacts of their mental health or carer status. In a national survey, 31 per cent of participants who had engaged with social security services reported being treated unfairly in applying for and getting welfare benefits or disability pensions. The same survey found evidence of stigmatising attitudes in the wider community, with nearly one in five respondents disagreeing that a mental health problem was a valid reason to be eligible for social welfare payments.[104] Significant structural barriers to accessing social security payments and other social services for people with personal lived experience are discussed below.

Reduce the complexity in accessing and navigating systems

Accessing and navigating highly complex social security payments and services systems can be difficult for everyone. It is particularly difficult for people with personal lived experience, who are often seeking these services and supports at times of greatest distress. Negative experiences trying to navigate these systems can worsen people's mental distress.[105] While there are some initiatives in relation to discrete aspects of social services[g], there is a noted lack of information and support to help people in mental distress access and navigate these systems. There is a need for

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[g] For example, psychosocial recovery coaches work with National Disability Insurance Scheme participants and their families, carers and support people to design plan and implement plans.

targeted, clear and accessible information and supports such as translation services, particularly for culturally and linguistically diverse communities.[106,107]

Design application processes and eligibility requirements that are appropriate for people with personal lived experience

Applying for income support carries a high administrative burden for people with personal lived experience. Applicants for social security services are asked to absorb the significant out-of-pocket costs of sourcing psychiatric or psychological assessment, which is required to support their application. Recent policy reforms that reduce spending on the Disability Support Pension had limited input from people with personal lived experience. As a result, current application and eligibility assessment processes carry the potential for negative consequences for applicants with personal lived experience.[108]

Assessments of eligibility for income support are often framed in a way that is more appropriate for physical disability rather than mental health issues. For example, to access Disability Support Payment, applicants are required to provide evidence that their condition is “fully diagnosed, treated and stabilised” (i.e. a doctor must demonstrate the condition is unlikely to change in the next two years, even with treatment). This discriminates against people experiencing mental health issues, whose symptoms and diagnoses may change over time depending on the health provider’s judgment and episodic nature of many psychosocial conditions. It is also not clear what level of mental health training/understanding is required of people who assess applications. While evidence shows many people who are denied the Disability Support Pension are granted access on appeal, the appeal process typically requires involvement of a legal advocate, which is out of reach or unaffordable for many people with personal lived experience.[109]

People also face complex application processes for accessing funding for psychosocial supports through the National Disability Insurance Scheme (NDIS). Recent legislative changes have sought to clarify that the NDIS requirement for a permanent disability includes episodic and fluctuating needs.[110] Work is also underway to support improved understanding of and responses to psychosocial disability, through the recent introduction of the NDIS Psychosocial Disability Recovery-Oriented Framework. However, the impact of these changes is yet to be seen, and more work may be required to monitor and unpack what they might mean in practice for people with personal lived experience.

People receiving JobSeeker payments are required to perform mandatory job applications and other job seeking activities. Although recipients can be exempt from these activities due to medical reasons (for example, a job seeker may refuse work that is ‘unsuitable’ because it aggravates a pre-existing illness, disability or injury), it is unclear whether current systems of medical evidence around such exemptions adequately account for the impact of ongoing and episodic conditions, including mental ill-health. This is challenging for people with episodic experiences of mental ill-health, who must repeatedly source medical certificates to verify the same (ongoing) conditions and care needs. Medical certificates for conditions deemed to be permanent are also not accepted as proof for exemption from obligations, with evidence of this occurring frequently among people with mental health diagnoses.[111]

Ensure mental ill-health is not a barrier to safe, secure, affordable and good quality housing

People with personal lived experience can face challenges in accessing and maintaining adequate housing due to stigma and discrimination.[112] Mental ill-health has been found to directly impact housing stability, measured by increased risk of forced moves and financial hardship.[113] Twelve per cent of a nationally representative sample of people with personal lived experience reported being treated unfairly in housing (including renting and accessing public or community housing), [114] and this figure was almost 40 per cent among respondents to a survey of people with complex mental health needs.[115] Barriers to equitable access to stable housing include discrimination by private landlords and housing officials, household members and neighbours. [116,117] People with diagnosed mental health conditions are 39 per cent more likely to experience a forced move within one year compared to the general population.[118] Eviction of tenants without cause, permitted in most Australian jurisdictions, causes housing insecurity and increases the risk of stigma and discrimination by landlords against people with personal lived experience.

People with complex mental health needs such as those who experience psychosis experience higher rates of homelessness compared to the general community.[119] Estimates range from 30 to 85 per cent of people experiencing homelessness living with a mental health issue. Perceived experiences of stigma and discrimination regarding private rental housing were much higher than in public or community housing and homelessness services. [120] For example, landlords may refuse potential renters if they disclose their mental ill-health and they may be at higher risk of eviction.[121,122] This can lead to people with complex mental health needs stopping themselves from reporting maintenance issues or making complaints to their landlords or housing officials, or withdrawing from relationships with household members and neighbours. [123] Similarly, stigma surrounding mental health often stops people from applying for homelessness services, or leads them to leave homelessness services before they are ready to. [124]

According to the Our Turn to Speak survey[h], other barriers faced by people with complex mental health needs while accessing or maintaining housing and accommodation services include:

- their uncertain financial and/or employment situations
- receiving the disability pension
- living with a service assistance dog
- participants’ complex mental health needs not being understood or taken seriously. [125]

Safe, secure, affordable, and good quality housing is essential to maintaining general health, mental health, and recovering from mental distress and physical illness. Stigma or discrimination on the basis of physical health issues and gender can also be barriers to housing security. [126]

Stigma and discrimination toward Aboriginal and Torres Strait Islander communities stemming from colonialism, racism, paternalism, disadvantage and lack of acknowledgement of culture mean these communities face compounded challenges in accessing and maintaining adequate housing. The housing needs for Aboriginal and Torres Strait Islander people must account for both social and cultural determinants of health to prevent discrimination, including cultural understandings of family, kinship and community, and connection to Country.

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[h] This survey is conducted by SANE Australia as part of the National Stigma Report Card, a project which aims to gather Australian evidence on stigma and discrimination for people experiencing complex mental ill-health. A total of 1,912 people living with complex mental ill-health completed the survey between 2019 and 2020.

Remove stigma surrounding parents' mental health in child protection decisions

Typically, families in contact with child protection services will experience multiple, complex issues, which may include parental mental ill-health and experiences of trauma.[127] Experiences of mental ill-health do not inherently prevent parents from being able to provide their children with appropriate care, support and safety. Despite this, parental mental ill-health is generally included in risk assessments as a risk factor for child safety in a way that is stigmatising and discriminatory – particularly when services are not accessible to support these parents with their mental health. [128]

It is well-known that Aboriginal and Torres Strait Islander parents are overrepresented in child protection systems. This shows the intersection of “experiences of racism in workers, systemic racism and systems bias,” which impacts on, for example, reporting of suspected child abuse and neglect.[129] Aboriginal and Torres Strait Islander people often experience intergenerational trauma due to the legacy of the Stolen Generation.[130]

Contact with child protection services is associated with additional stigma. For instance, many parents feel stigmatised as ‘bad parents’ or ‘failures’ because of their involvement with this service system.[131] Stigma can cause or compound parental mistrust towards child protection workers. This in turn can lead to a cycle where child protection workers cannot provide as much support to parents, make referrals to services to improve their parenting skills, or address other risks within the family environment.[132]

The training, academic and professional backgrounds of child protection workers are not typically focussed on addressing parents' experience of mental ill-health. Instead, training focuses on reactive approaches to risk.[133] This means these workers are unlikely to be able to challenge stigmatising and discriminatory responses to parents with personal lived experience.

The experience of stigma and discrimination is likely to be lower for services and systems that take integrated and inclusive service approaches. Examples of areas of opportunity and best practice that relate specifically to child protection include:[134]

- Outreach models for parents engaged in child protection to enable early referral to evidence-based supports to strengthen their parenting skills in the context of their mental health support needs. Ideally, these referral pathways would be available to parents before they are involved with child protection services, however, current intensive support programs do not address mental ill-health well.

- Support for Courts to enable them to consider therapeutic responses in decision-making. NSW and Victoria's specialised, independent Children's Court Clinics provide an example of a therapeutic and child-centred model of care that provides magistrates with information to guide decision processes of the Court. Magistrates refer complex child protection matters to the Clinics, who assess psychosocial issues affecting the child's life and wellbeing and make recommendations around what outcome would best meet the child's needs.

- Multidisciplinary and cross-sectoral collaboration and knowledge-sharing, including case assessment procedures and case conferences. This could focus heavily on trauma-informed practice and decision-making.

- Support for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities to build culturally safe child protection responses.

There are common enabling strategies across all social services to support the elimination of stigma and discrimination

Through an analysis of the challenges in reducing stigma and discrimination in social service systems, and feedback from people with personal lived experience, common strategies were identified that enable these systemic challenges to be overcome. These include:

- Developing, implementing and adequately resourcing training for people working in social services, led by people with personal lived experience, to help them identify and eliminate stigmatising or discriminatory practices, attitudes and behaviours. Training should use a trauma-informed approach, build trainees' understanding of the social determinants of health, and include narratives of hope and recovery.[135,136]

- Embedding peer support workers in social and welfare services to help people experiencing mental distress navigate these systems, provide ongoing individual advocacy, and link people to other services that can help to meet their intersecting needs (such as mental health, housing and homelessness, and safety from violence).[137,138,139] However, services need to be responsible and accountable for improving access, integration and navigation for people with personal lived experience so that the responsibility does not fall entirely on individuals and the Lived Experience workforce. [140]

- Reforming application and compliance processes that disadvantage people with personal lived experience and their families and support people, including eligibility and assessment processes, inflexible compliance activities and exemption rules.[141] This could be achieved by shifting focus away from assessing an individual's 'impairment' and more strongly towards the barriers they may encounter in the world around them, consistent with the social model of disability.[142]

- Ensuring people have alternative ways to access information and services and are not excluded by not having access to technology (such as a My Health Record or state and territory service system apps), or not being comfortable or having the skills to use it.

- Eliminating stigmatising language and frameworks in policy, media and services. Messaging should include compassionate depictions and discussions of people with personal lived experience who access social services and focus on strengths and individual needs rather than risk. An example of this would be considering the support someone may need to maintain a tenancy rather than the risk they may pose to the provider's property.[143] This may also be facilitated by providing a platform for people with personal lived experience to speak about their experiences – including those of stigma and discrimination in social services systems.

- Increasing the availability and equity of support for support people.

- Improving prevention and early intervention by supporting social services to:

    - recognise the way systemic failures to provide housing and income support can cause and intensify mental ill-health, trauma, and distress

    - be better equipped to work with people before they get to crisis point

    - better integrate funding and systems to streamline processes and create a more accurate picture of an individual's needs.

> *“The more [different social services systems] work together the better they are. We can learn from each other and build a smarter system together.”*

WORKSHOP PARTICIPANT

Priority actions for social services

Priority actions to ensure social services, including social security, disability supports, housing and child protection, are equitable and non-discriminatory are listed in the table below.

Ref	Action	Timeframe	Who’s responsible	Expected changes
2.3a	Ensure people have alternative ways to access information and services, in addition to digital access	Short term	Australian, state and territory governments	Decrease in people with personal lived experience reporting barriers to accessing social services and navigational support due to technology access/literacy
2.3b	Review the extent of stigmatising and discriminatory language and approaches in risk assessments in social services. Amend where necessary to ensure strengths-based messaging and framing	Medium term	National Mental Health Commission	Increase in risk assessment processes that take a strengths-based approach
2.3c	Develop principles and standards for nationally consistent training to build capability in social services in relation to supporting people with personal lived experience	Medium term	National Mental Health Commission	Development of training advice
2.3d	Develop and deliver tailored training (consistent with principles and standards – see above 2.3c) for people working in social services, led by people with personal lived experience, that builds trainees’ understanding of the social determinants of health, the impact of co-occurring conditions and includes narratives of hope and recovery	Medium term	Australian, state and territory governments	Decreased prevalence of stigmatising attitudes amongst social services employees Decreased in number of people with personal lived experience reporting stigma and discrimination in their interactions

Ref	Action	Timeframe	Who's responsible	Expected changes
				with social services staff
2.3e	Embed peer-support workers in social and welfare services to support people with personal lived experience and families and support people to navigate the services system and link them to other services where appropriate	Medium term	Social service providers	Decrease in people with personal lived experience reporting barriers to accessing social services and navigational support
2.3f	Build on existing work to ensure the NDIS: • is based on a model of disability that includes the impacts of mental ill-health, distress and trauma • ensures parity of psychosocial disability with other forms of disability, including through systems, processes and staff knowledge and skills • recognises and aligns in-practice with the potentially episodic nature of mental ill-health, trauma and distress, and recovery principles • does not further contribute to people's experience of stigma and discrimination.	Medium term	National Disability Insurance Agency	Increased access to NDIS supports among people with personal lived experience
2.3g	Scope feasibility of amending eligibility and supporting guidance for Disability Support Pension and Carer Payment to: • be based on a model of disability that includes the impacts of mental ill-health, distress and trauma • ensure parity of psychosocial disability with other forms of disability • recognise the potentially episodic nature of mental ill-health, trauma and distress	Medium term	Department of Social Services	Increased financial security for people with personal lived experience and for carers and support people
2.3h	Integrate funding, data, and systems across social services to streamline processes and identify individuals' need or eligibility for all necessary services to address holistic needs	Long term	Australian, state and territory Governments	Ability to share relevant information to address holistic needs

Ref	Action	Timeframe	Who's responsible	Expected changes
2.3i	Review and reform or repeal tenancy laws that perpetuate stigma and discrimination of people with personal lived experience, and families and support people, including those that permit eviction without cause	Long term	State and territory governments	Decrease in number of people with personal lived experience reporting stigma and discrimination related to housing
2.3j	Increase employment opportunities available to people with personal lived experience, and support people, who can and wish to work	Long term	Department of Employment and Workplace Relations	Increase in number of people with personal lived experience engaged in employment which does not exacerbate their distress
2.3k	Increasing the flexibility of compliance (i.e., job-seeking) activities for people with personal lived experience, and support people, who receive income support payments	Long term	Department of Employment and Workplace Relations	Reduction in number of people with lived experience not meeting compliance obligations
2.3l	Improve child protection supports by: • implementing outreach models early on for parents engaged in child protection, to understand how their experience of mental ill-health is being managed, and provide comprehensive referral pathways based on support needs • support Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities to build community and culturally aware child protection responses • promote multidisciplinary and cross-sectoral collaboration and knowledge-sharing, focussed on trauma-informed practice and decision-making	Long term	State and territory governments	Increased uptake of early outreach referral pathways amongst parents with personal lived experience Presence of trauma-informed policy and practice across child protection agencies in relation to matters involving parents with identified personal lived experience Decrease in number of Aboriginal and Torres Strait Islander and culturally and linguistically diverse

Ref	Action	Timeframe	Who's responsible	Expected changes
				parents reporting stigma and discrimination due to mental health status in child protection intake, assessments and matters

2.4 Support people to have equitable access to financial services and insurance

People with personal lived experience may face structural discrimination in the financial and insurance sectors. This acts as a barrier to equal access to broad services including insurance, financial loans, and other financial products. When surveying people with complex mental health needs, half of all respondents reported being subject to some level of stigma or discrimination in financial and insurance services in the past 12 months, and approximately seven per cent identified these industries as one of the three domains where they have been most affected by stigma and discrimination. Of all domains considered in that study, reports of positive experiences in connection with mental health issues was lowest in financial and insurance services.[144]

People with complex mental health needs commonly reported being denied insurance and loans due to their mental ill-health and/or due to their status as recipients of the Disability Support Pension. Respondents also reported being uncomfortable about the level of detail regarding their mental health they were asked to share with service providers. Only one in five respondents reported having positive experiences of accessing financial and insurance services in response to their complex mental health needs (e.g., receiving special consideration to better meet their needs). Other personal characteristics that led to intersectional experiences of stigma and discrimination relating to finance and insurance were reported. The most frequently cited factor was physical health status, and others included age, disability, physical appearance, weight and financial circumstances.[145] The experience of financial distress can also carry its own stigma, linked to perceptions of societal beliefs that financial wellbeing is due to personal responsibility and an indicator of 'success' in life.[146] This can further compound the impacts of mental health-related stigma and discrimination.

Support access to and empowered decision-making regarding financial services

Financial services include banking products (e.g. deposit products), consumer credit (including credit cards, car loans, home loans and small amount lending – sometimes known as 'payday lending') provided by a range of bank and non-bank lenders, superannuation and general and life insurance. Experiences of debt collection and bankruptcy proceedings also come within this space.

Mental health-related stigma and discrimination is common in financial services. Over 60 per cent of respondents with complex mental health needs who had tried to access banking products in the past 12 months reported being treated unfairly when trying to apply for products.[147] [28]Workshop participants with personal lived experience – and particularly of being a support person or carer – spoke of situations where their Powers of Attorney and Guardianship Orders were not recognised and acted upon by financial institutions.[148]

Engagement with people with personal lived experience indicates that the following responses would support a reduction in stigma and discrimination in the financial and banking sector:

- Enhanced supported decision-making so people with personal lived experience can avoid exploitation when accessing financial products and institutions and provide informed consent to a range of processes including the collection of personal information and the identification of support people to liaise with services on their behalf. Responsible lending practices should include guidelines around consent, decision-making and borrowing capacity in relation to mental ill-health.

- Improved processes and staff training within financial institutions to ensure Powers of Attorney, Guardianship Orders and advance directives are recognised and acted upon. Staff training policies should cover supporting clients who might be distressed generally, as well as strategies to counteract stigma.

- Mechanisms for advocacy, support and safeguards (e.g., reasonable adjustments to repayment schedules) to ensure people with personal lived experience are not discriminated against in accessing or seeking support in relation to financial products.

- Increased information and support for people with personal lived experience when engaging with the Australian Tax Office and income support agencies. Topics should provide clear guidance around debt recovery, applying compassionate grounds, and support available for navigation and advocacy.

- An independent body with authority to investigate and enforce accountability for the appropriate management of the financial affairs of a person with personal lived experience where another party (such as State Trustees) acts as that person's financial administrator.

Ensure people with personal lived experience have access to insurance that helps them return to work and to the community

Insurance is an essential means of protection against unexpected life events. However, people with personal lived experience report experiences of stigma and discrimination throughout the entire insurance lifecycle, from the point of application through to claims and complaints. In one survey, amongst people with complex mental health needs who had accessed insurance products during the previous 12 months, almost 90 per cent reported being treated unfairly by insurers, including when trying to apply for products.[149] People also report lengthy claims processes, slow dispute resolution and are twice as likely to experience disputes over the evidence in support of a claim.[150]

Other reported barriers include being denied access to insurance, facing difficulties when attempting to claim against their existing insurance policies, being granted access to insurance with higher premiums or unfavourable terms and exclusions that are not relevant or proportionate to their experience of mental ill-health or suicidality, and/or having their insurance claims denied (e.g. mental ill-health claims have one of the highest rejection rates of all Total and Permanent Disability claims).[151,152]

Underpinning many of these experiences is the fact that the insurance model is 'discriminatory by nature'[153] and, by design, seeks to differentiate between different categories of risk in the terms and pricing of insurance products. This is reflected in the partial exemption under section 46 of the *Disability Discrimination Act 1992* (Cth) that means discrimination on the basis of disability (including mental ill-health) is not unlawful in certain circumstances – namely, where there is actuarial data on which it is reasonable to rely, or, if that data is not available, having regard to any other relevant factors.

> *"I have an insurance exclusion for mental health despite not having an episode for 12 years. When interviewed or [completing] paperwork, [they] never ask what is being done to manage…no recognition of recovery. All levels of mental illness are seen as the same."*

WORKSHOP PARTICIPANT

The extent of compliance with these provisions and other industry practices that contribute to experiences of stigma and discrimination in insurance have been the focus of advocacy efforts for more than 10 years.[154,155] The issues have also been closely examined by a number of significant recent enquiries.[156,157 ,158 ,159] In particular, the Productivity Commission's Mental Health Inquiry report included a detailed consideration of the issues and recommended a suite of changes to support more equitable treatment and access to insurance for people with personal lived experience.[160]

These enquiries have prompted significant reform to legal and regulatory frameworks around insurance and to industry practices. Examples of changes include the implementation of mental health awareness training for relevant employees, the creation of specific roles for claims involving mental ill-health, industry guidance around working with 'vulnerable' customers, and bans on blanket exemptions on the basis of mental ill-health. Many of these protections have been incorporated into recently revised industry Codes of Practice[161,162] and standards.[163,164]

However, the impacts of such reforms are yet to be seen, and there remain several practical and systemic issues that require focussed attention and action, including:

- the extent to which stigmatising or discriminatory experiences in insurance in relation to mental ill-health are being detected, responded to and influencing industry adaptation and innovation
- whether the type of training being provided to people working in insurance is fit for purpose, effective and includes specific focus on stigma-reduction, and what quality assurances and oversight mechanisms are in place to support evaluation and improvement of these programs over time
- whether the underwriting practice of taking into account a person's history, severity or type of mental health condition[165] also includes consideration of protective factors (e.g. social supports, living arrangements, employment history)
- potential underwriting impacts of inconsistencies across the medical profession in understanding, diagnosis and treatment of mental ill-health[166]
- whether the standard and volume of information required by insurers to assess the impact of mental ill-health is unreasonably high compared to other types of claims (noting that 'objective' evidence can be challenging given the inherent subjectivity of experiences of mental ill-health)

- the extent of progress towards alternative approaches to assessing the impact of mental ill-health for insurance purposes, including to move away from the use of Activities of Daily Living assessments, which are not fit for purpose in relation to mental ill-health.
- whether insurers are providing a sufficient level of detail in their reasons for decisions, for example, to illustrate a direct connection between the prognoses of pre-existing mental health conditions as the basis of rejected claims.

Fundamentally, the industry (particularly in relation to life insurance) needs to adapt its approach, both culturally and systemically, to better align with changing societal attitudes and approaches to support and treatment for mental ill-health. People experience mental ill-health differently and to different extents, even if they have the same diagnosis. Although insurance is a risk-based industry, risk assessments need to look beyond a person's diagnosis to understand their personal circumstances and abilities, and also consider protective factors.[167,168]

There is a central need for more granularity and nuance in differentiating between different diagnoses and other factors that influence a person's experience of mental ill-health. This places an emphasis on more detailed and consistent approaches to data – in its collection, categorisation, analysis and integration (including into underwriting and pricing). This applies to both claims related to mental ill-health, as well as population-based analyses for the purposes of broader industry insights and planning.

There is also a parallel need for strengthened accountability, including transparency around insurance decisions and data, and tracking whether industry codes, guidelines and frameworks (e.g. mental health claims management frameworks and guidance on the application of the *Disability Discrimination Act*[169]) are consistently and effectively implemented in practice. This may require further work around the role of code compliance committees and the 'enforceable code provisions' regime administered through the Australian Securities and Investment Commission.[170] In this context, strengthened accountability also means ensuring complaints processes (e.g. directly through insurers, or through bodies such as the Australian Financial Complaints Authority and the Australian Human Rights Commission) are well understood, accessible and accessed in practice by people with lived experience.

Given the significant complexity in this space (see Box 3, below), there may be value in exploring opportunities for stronger regulatory engagement and oversight to ensure that people with lived experience have appropriate supports and the full benefit of protections against discrimination in insurance.

Box 3: Complex policy and regulatory landscapes

As noted by the Productivity Commission, there is significant complexity in the legal, regulatory and policy landscape of the insurance industry,[171] and the way in which it intersects with other systems that seek to support people's financial security and economic dignity.[172]

Insurance is one of several major systems of income support in Australia, alongside employer-provided entitlements, workers compensation and social security payments. As examined by work undertaken through the Collaborative Partnership for Improving Work Participation, these systems form a complex, intersecting yet fragmented landscape, in terms of funding arrangements, regulations, rules and processes, and in the levels and types of services and support they provide to individuals requiring financial assistance.[173] A further complexity is that movement of people between these systems is common, but also highly individualised, with no clear 'pathways' of transition.[174]

People with personal lived experience are amongst the highest users of these systems. However, as this (Draft) Strategy indicates, they also experience inequitable access and unfair treatment across all of these systems. When considered alongside other factors such as costs of services, challenges in education and employment, and other intersectional experiences of disadvantage, the clear cumulative impact of stigma and discrimination is to place people with personal lived experience (and particularly people with complex mental health needs) at a substantial systemic disadvantage.

Financial insecurity and precariousness have been key themes running through several areas of focus for this (Draft) Strategy. While outside of scope for this work, the Commission notes there are some fundamental considerations to be had around the intersecting roles, incentives and regulation of each of the different systems involved in supporting the financial security and economic dignity of people with lived experience.

Priority actions for financial services and insurance

Priority actions to support people to have equitable access to financial systems and insurance are listed in the table below.

Ref	Action	Timeframe	Who's responsible	Expected changes
2.4a	Develop guidance and incorporate Lived Experience workers into financial and legal services to assist clients in navigating these complex service systems and to advocate at an individual and system level	Short term	National Mental Health Commission Financial and legal service providers	Improved understanding of financial and insurance systems amongst people with personal lived experience
2.4b	Explore opportunities to develop – and embed in financial services and insurance products, practices and reporting – common definitions of relevant data that reflect contemporary understandings of	Medium term	National Mental Health Commission	Increased evidence of contemporary and informed policy and practice relating to providing services to people

	causes, experiences and impacts of mental ill-health, and include clinical diagnoses as well as sub-clinical presentations			with personal lived experience
2.4c	Review and update as required, industry guidelines and training opportunities for members to ensure they: ● reflect contemporary, strengths-based understandings of mental ill-health ● outline the impact of stigma and discrimination and for people when accessing financial services, and provide practical guidance for preventing and addressing these impacts (e.g. through ‘reasonable adjustments’) ● are independently reviewed and accredited with input from people with lived experience and other mental health expertise ● include components that are delivered by people with lived experience ● promote mechanisms to ensure Powers of Attorney, Guardianship Orders and advance directives are recognised and acted upon	Medium term	Industry peaks*	Improved understanding of mental ill-health among finance and insurance professionals
2.4d	Continue and strengthen work to improve financial and insurance products, as well as providers’ policies and procedures, so they • recognise that recovery from mental ill-health, trauma or distress can be non-linear and episodic in nature • ensure a person’s individual experience is appropriately considered • ensure providers apply reasonable adjustments e.g., to repayment schedules, debt recovery, guidance on ‘compassionate grounds’	Medium term	Financial and insurance services Industry peaks* Australian Securities and Investments Commission	Decrease in number of people with personal lived experience reporting being unfairly denied access to financial and insurance services, or having services unfairly suspended or cancelled, due to stigma and discrimination
2.4e	Review rules and protections around how information in Mental Health Treatment Plans (or equivalent care plans) and other medical records can be requested, shared and interpreted	Medium term	Australian Government, industry peaks* and mental health professional peaks	Alignment of rules and protections for the use of Mental Health Treatment Plans and other

	for the purposes of finance and insurance matters			medical records with best practice principles
2.4f	Ensure product design and distribution, services and polices are informed by accurate and relevant data by ensuring relevant data for the insurance industry includes data on workplace interventions, claims and insurance from employers, workers' compensation schemes, individual and group life insurers	Medium term	Employers Insurance services Industry peaks*	Enhanced access to relevant data by financial and insurance services to support product and service design
2.4g	Explore opportunities for data collection and reporting to achieve greater accuracy and transparency in relation to mental ill-health and access to insurance. This should include consideration of: • collecting and publishing data about the incidence of mental ill-health as a cause of insurance claims for the purposes of actuarial analyses and product design • opportunities to establish baseline compliance with recently revised standards and code of practice provisions, against which further improvements can be measured. • tracking of the implementation and impact of recent industry reforms, codes of practice and standards, education and training, and effectiveness of oversight and enforcement mechanisms • review of progress against actions in this (Draft) Strategy as well as any outstanding issues identified by previous inquiries • a schedule for review and reporting over both medium and longer-term timeframes	Short term	National Mental Health Commission Australian Prudential Regulation Authority Industry peaks* Code compliance committees (or equivalents) Australian Financial Complaints Authority	Agreement on a clear plan for future reporting, including on key areas of content and data and commitment to timeframes.
2.4h	Consider impact of existing industry standards and reforms, to identify and act upon areas requiring further improvement to ensure equitable access to insurance and other	Long term	Industry peaks Australian Government	Increased adherence to industry codes of practice

	financial services including consideration of: • mechanisms to support effective implementation of codes of practice • the need for further workforce supports, such as training, education or guidelines, or other improvements to products and/or industry policies and practices • opportunities to make code of practice provisions binding			
2.4i	Explore and embed supported decision-making mechanisms to protect people with personal lived experience from exploitation when accessing insurance and financial products	Long term	Australian, state and territory governments Industry peaks*	Increased availability and uptake of supported decision-making mechanisms in financial and insurance services

*Industry peaks refers to peak representative bodies in financial services including (but not limited to) the Financial Services Council, Insurance Council of Australia, and the Australian Banking Association, the Customer Owned Banking Association and the National Insurance Brokers Association.

2.5 Support people to receive equitable treatment by legal systems

Structural discrimination in legal, justice, police and correctional systems acts as a barrier to equal access to services for people with personal lived experience and can have significant and long-lasting impacts.

The proportion of people with personal lived experience is higher among people in contact with the justice and legal systems compared to the general population. Given that people in contact with the justice and legal services are also stigmatised, potential exists for compounding stigma and discrimination for those with both personal lived experience and contact with these services. This leads to poorer outcomes not only in comparison to the general population, but also in comparison to those with personal lived experience or contact with these services alone.[175] Further, experiences of stigma in justice and legal services can be compounded by stigma and discrimination in relation to people's physical health or disability, their racial or cultural background, gender, alcohol or other drug use, and lower socio-economic status.[176,177,178]

> *"The legal system is complex and has a lot of structural violence built in."*
>
> WORKSHOP PARTICIPANT

Efforts to address structural stigma and discrimination in justice and legal services should focus on improving police responses to incidents involving people in mental distress, increasing access to legal representation, improving access to appropriate mental health care in correctional settings, including access to supported decision-making, and enhancing transparent decision-making in family law matters.[179]

Improve police training and responses to mental health-related incidents

A major area where people report experiencing stigma and discrimination in relation to justice and legal services is in responses to mental health-related incidents. This has been reported in particular in relation to police, but also lawyers or court officials, and child protection officials.[180, 181] Unfair treatment is described by the majority of people with complex mental health needs as being unfairly detained or questioned by police, being subjected to excessive police force, or being unfairly denied police assistance when needed. [182] This unfair treatment is presumed to be driven by a lack of understanding of complex mental health needs, including the impact that trauma can have on someone's response to stressful situations. [183] Discriminatory police responses are also said to stem from negative stereotypes about people with personal lived experience having impaired decision-making or awareness. [184] This highlights the importance of targeted education and training for this cohort.

Police are typically the first responders to incidents involving people experiencing mental distress, ill-health or trauma. However, there is broad acknowledgement of the limitations in police training and the scope of their role in these situations. Efforts have been made to improve police responses and promote inter-agency collaboration in crisis response. These include a suite of programs and services supporting and advising police,[185] such as the Victorian Police Ambulance and Clinical Early Response (PACER) program, which is a "joint crisis response from police and mental health clinicians to people experiencing a behavioural disturbance in the community."[186] Evaluations of the PACER service in Victoria indicate that it works well, but that workforce challenges exist in rural areas, and that the program should be expanded in high-demand areas.[187]

Provide legal practitioners and judicial officers with mental health training

Stigma and discrimination can manifest as a barrier to accessing legal services or representation, sometimes through being denied access. [188, 189] Survey respondents with complex mental health needs reported stigma led to them being unfairly denied the right to report a crime, or access legal services or advice.[190] A further barrier to access occurs when individuals stop themselves from accessing these services, because they anticipate being treated unfairly due to past experiences of stigma. Around half of survey respondents with complex mental health needs had in the previous year stopped themselves from reporting a crime, asking for help from police, calling 000 in an emergency, or seeking legal services or advice when they needed it, because of stigma.[191]

Despite the high rates of contact between legal practitioners, judicial officers and people with personal lived experience, there is no requirement for these professionals to undertake forensic[i] or other forms of mental health training.[192] There are efforts underway in Legal Aid services to provide training to ensure quality presentation of mental health expert evidence in cases involving clients with personal lived experience or with cognitive impairment.[193]

Provide appropriate mental health care in correctional settings

Rates of mental ill-health (including alcohol and other drug use) amongst prison entrants are almost double the rate of the general Australian population. Offenders with a mental health

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[i] Forensic mental health is a specialised field within mental health that deals with the clinical and legal aspects of mental ill-health in legal and justice settings and systems.

diagnosis are also more likely to be convicted and incarcerated than offenders without a diagnosis. The overrepresentation of people with personal lived experience in correctional settings persists in Australia despite the "range of special considerations, provisions, and sentences" that can be made for people with personal lived experience.[194]

The 'equivalence of care' principle means that prisoner health services are required to provide care of the same quality to that provided in the general community in the same country. In the community, people can access Medicare rebates for up to 10 allied mental health services in a year. However, in prison, most prisoners have limited access to ongoing counselling and other individual therapies, particularly for the treatment of common mental disorders like depression.[195] The poorer mental health outcomes of people with personal lived experience in custody compared with the general prison population reflects the lack of access to adequate mental health care in correctional facilities in most Australian states and territories.[196]

Correctional, court and forensic systems can also discriminate against people with personal lived experience. For example, in court settings, there are inconsistencies in the recognition and consideration of a person's metal health during the legal process. In correctional settings, those with mental ill-health may be denied access to rehabilitative programs, be less likely to be eligible for release programs and be detained for extended periods when their fitness to be tried is assessed as 'impaired'.[197,198] People within the forensic mental health system may be detained for longer periods of time than the prison sentence they would otherwise have received, or detained indefinitely.[199] Across all of these settings, there can also be a lack of access to supported decision-making processes.

Establish more transparent legal decision-making relating to parental mental health

There is no or limited data to identify systemic discrimination or stigmatising practices in family court matters toward parents with personal lived experience.[200] One way of building this evidence base, and to ensure any stigmatising or discriminatory practices are challenged, would be to encourage the courts with jurisdiction in family law[j] to disseminate practice developments and clarify practice directions to parents and their legal representatives.[201]

It is fair to assume that many people with personal lived experience are also parents. People with personal lived experience face structural stigma and discrimination if they have contact with family law matters and child protection systems (discussed further at *2.3 Ensure social services, including social security, disability supports, housing and child protection are equitable and non-discriminatory*). However, there is limited available literature directly connecting parents' experiences of these systems and mental ill-health.[202] Courts with jurisdiction in family law and the services that intersect with them, including mental health and domestic and family violence services, need to be equipped to respond adequately to the needs of parents.

Parental mental health issues play a large role in family law matters decided by courts, particularly when parents are unable to agree on parenting matters and judges are required to determine where children reside and spend time with parents after families separate.[203] International evidence shows that structural discrimination against parents with personal lived experience often manifests in the loss of custody of their children.[204]

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[j] Broadly encompassed by the Federal Circuit and Family Court of Australia (FCFC) administrative structure, plus the Family Court of Western Australia.

Training to encourage collaboration between workers in family courts systems and other sectors would be beneficial. Some evidence suggests lawyers should “assist beyond litigation, including taking more time to explain the legal process, assisting with administrative tasks, and coordinating with other supports and services.”[205] A growing body of evidence suggests a need for “trauma-informed service provision for parents and children in the child protection as well as the family law systems.”[206] South Australia’s Mental Health Liaison Project is a model which improved the skills of practitioners working across parental mental health and child protection services and facilitate intersectoral collaboration.[207]

Priority actions for legal systems

Priority actions to support people to receive equitable treatment by legal systems are listed in the table below.

Ref	Action	Timeframe	Who’s responsible	Expected changes
2.5a	Improve knowledge and awareness of mental health through training co-delivered with people with personal lived experience: • Provide a manual and deliver a program of education for judges to inform court procedures and decisions involving people with personal lived experience, including when self-represented • Develop and implement continuing legal education for lawyers and legal support roles to provide extended support for clients with personal lived experience • Incorporate content regarding rules for accessing Mental Health Treatment Plans (and equivalent care plan) and medical records in training and guidance for lawyers and people working in courts, as well as health professionals as data custodians • Build mental health literacy of workers in child protection and family law	Medium term	Law Council of Australia State and Territory Bar Associations Courts (including Federal Circuit and Family Court of Australia; Family Court of Western Australia and other courts) National Judicial College of Australia (NJCA) Australasian Institute of Judicial Administration (AIJA).	Increased understanding of mental health among legal and justice professionals

Ref	Action	Timeframe	Who's responsible	Expected changes
2.5b	Review justice system rules and protections around the use of Mental Health Care and Protection Orders, including in family law matters, child protection and custody cases, to prevent discrimination and to encourage people to seek help	Medium term	Australian Law Reform Commission	Increase in number of people with personal lived experience help-seeking Reduced reports of unfair or discriminatory treatment on the basis of mental ill-health
2.5c	Rigorously document, disseminate and provide clarification of practice developments and practice directions related to mental ill-health and family law that courts provide to judicial officers, registrars and court staff and evaluate impact on behaviour and outcomes	Medium term	Courts with family law jurisdiction (Federal Circuit and Family Court of Australia; Family Court of Western Australia)	Evidence of court procedures which include dissemination of practice developments and directions
2.5d	Protect people with personal lived experience from exploitation by systematically embedding mechanisms for supported decision-making in legal proceedings, correctional settings (including the forensic system) and in accessing insurance and financial products	Long term	Australian Government	Increased uptake of supported decision-making mechanisms by people with personal lived experience

2.6 Build equitable and supportive pathways into and within employment

Structural discrimination in employment relates to the presence of policies, procedures or practices within organisations, and the regulatory and operating environment of employers, that restrict the opportunities for employment for people with personal lived experience, or which fail to adequately support people with personal lived experience who are employed.

Recent Australian data indicates that one in three people with personal lived experience who are employed experience discrimination in the workplace, and people with personal lived experience are more likely to experience discrimination than positive treatment while looking for work.[208,209] These experiences are more common for people with complex mental health needs, and are compounded for people who experience intersecting forms of stigma and discrimination (for example, people from culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, and/or people who are trans and gender diverse) who are more vulnerable again to discrimination in employment.

The impacts of stigma and discrimination in employment also affect businesses through a loss of diversity and talent to the workforce. In many cases, stigma may cause employers to miss out on the best person for the job, or unrealised opportunities for product and service improvement.

Clarify and implement existing protections

Maintaining mentally healthy workplaces is a foundation for guarding against experiences of stigma and discrimination in employment. Requirements to protect psychological health and safety already exist under workplace health and safety legislation. These arrangements operate on the basis of risk identification, with a focus on controls for reducing and eliminating ‘psychosocial hazards’. What these risks are in each workplace will vary depending on sector, size of business, individual roles and relationships, and a range of other workplace-specific factors. Therefore, each workplace is responsible for identifying its own risks and developing its own approach to managing these.

Similarly, addressing mental health-related stigma and discrimination in the workplace needs to be tailored to circumstance. However, there are broad parameters that workplaces may find helpful in these making considerations. For example, employers have a legislative obligation to make ‘reasonable adjustments’ to work arrangements for people with a disability. What might be ‘reasonable’ will depend on the specific role, the particular circumstances of the individual and the needs of the employer. It is difficult to provide definitive rules for every situation, but guidance and examples may be instructive.

The judgment of individuals can significantly influence how existing protections are interpreted and applied in practice. It is important that stigmatising attitudes and behaviours do not unfairly skew systemic outcomes of such processes. This underlines the importance of ensuring a minimum level of tailored, role-specific understandings around the interaction between experiences of mental ill-health, stigma and discrimination, and employment, particularly for Human Resources professionals and people in management positions. (See also the actions under *Priority 3: Reduce public stigma*, below)

To achieve a minimum level of understanding, many workplaces may require a capability uplift for employees in relevant roles. This may include overarching guidance and resources around having meaningful, supportive conversations about mental health that move beyond awareness to address the actual application of workplace supports for mental health. It may also involve stigma-specific training and education, which could be incorporated into existing courses (such as mental health or physical health first aid) or delivered in stand-alone initiatives. Role-specific training and education for managers and people leaders should focus on building skills around supervising people with personal lived experience, including building capabilities in the use of support and planning tools.

There is also a need for clarity at a systemic level. Mental health in the workplace is governed by a complex patchwork of legal, industrial and regulatory arrangements. As a result, employers and employees are sometimes uncertain about their respective rights and responsibilities, legal obligations and/or the anticipated cost of reasonable adjustments (which are currently not clearly stipulated in legislation in relation to mental ill-health). This uncertainty can limit a person’s awareness of their rights and contribute to employer perceptions of risk in hiring people with lived experience.[210,211] There is a need for clearer legislative and regulatory guidance and oversight, and stronger communication of the business case for diversity in employment to include people with personal lived experience.

Break down barriers to employment

Expanding access to employment is a key strategy to improve equity for people with personal lived experience, as well as for families and carers. Through offering employment opportunities to people with personal lived experience, employers can support recovery and help to prevent the far-reaching negative outcomes of limited access to employment (including future unemployment, mental health, and social and economic inclusion). For businesses, it is also important to increase diversity of perspectives and experience among employees.

Ways to improve employment opportunities may involve: [212,213]

- equitable pathways into work, such as modified entry mechanisms, scholarships, and job-readiness training opportunities for people with personal lived experience
- job design and workplace flexibility, such as supported employment opportunities and positions (which may be offered as a steppingstone to other positions)
- individualised and collaborative approaches to onboarding, education, care planning and return-to-work processes that empower the person to voice their needs

A recent Australian survey found:

Half of respondents would not employ someone with known schizophrenia or borderline personality disorder

One in four respondents would not employ someone with known bipolar disorder, depression or who self-harmed

Source: BETA Baseline Survey Exploratory Analysis

- Developing and promoting strategies to support employees with personal lived experience or caring responsibilities
- focussed stigma-reduction initiatives within workplaces, given evidence that stigmatising attitudes among co-workers (even as a vocal minority) create major barriers to employment.

Further embed ‘peer champions’ and Lived Experience workforce roles

Expanding the availability of designated Lived Experience workforce roles is another option for reducing stigma and discrimination, as these roles can illustrate and emphasise the value of lived experience in the workforce. In addition, workplaces may explore the potential for ‘peer champions’ in existing roles as a way of increasing visibility and driving cultural change towards mental health. These considerations are particularly salient in sectors with direct exposure to people with personal lived experience (such as the health sector), but also in sectors where the peer support workforce currently has little exposure.

Importantly, these roles should only be pursued where they are likely to be supported by organisational culture, leadership and readiness for change. Poor planning, poor implementation and lack of appropriate supports for such roles can inadvertently lead to *increased* stigma and discrimination. Workplace culture that embraces diversity is a key enabler for the success of lived experience in both designated Lived Experience roles and non-designated roles. The *National Lived Experience (Peer) Workforce Guidelines* provide principles, information and practical resources that could be adapted to various setting to support considerations by leaders who wish to establish Lived Experience workforce roles in their organisations.[214]

Box 4: Spotlight on the Mentally Healthy Workplace Alliance

The Mentally Healthy Workplace Alliance brings together businesses, unions, government and workplace health and mental health sectors, with membership representing a commitment to provide collaboratively-developed, practical guidance to create mentally healthy workplaces. This incorporates a focus on making changes to business practices that are sustainable and measurable. The Alliance has developed the National Workplace Initiative, intended to partner with all Australian workplaces to provide a nationally consistent approach to mentally healthy workplaces.[215] [216]

Priority actions for employment settings

Priority actions to build equitable and supportive pathways into and within employment are listed in the table below.

Ref	Action	Timeframe	Who's responsible	Expected changes
2.6a	Conduct longitudinal research to collect population-level data on prevalence of structural stigma and discrimination against people who have personal lived experience in employment or seeking employment	Short term	National Mental Health Commission	Increased availability of longitudinal data on prevalence and experiences of stigma and discrimination in employment
2.6b	Develop guidance for employers across sectors, and of different business sizes, to advise on policies and procedures that support employees with personal lived experience, including: • changing stigmatising attitudes towards disclosures of mental ill-health and requests for reasonable adjustments • providing access to programs for people with personal lived experience to enter and be supported in the workplace, including flexible working arrangements, staying/returning to work plans, disclosure, individual placement support/mentoring and skills training Consult with people with personal lived experience from Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities to ensure the guidelines are culturally safe. Guidelines should focus on people	Short term	National Mental Health Commission Mentally Healthy Workplace Alliance	Decrease in prevalence of stigmatising attitudes in Australian workplace Decrease in prevalence of workplace experiences of stigma and discrimination among people with lived experience

Ref	Action	Timeframe	Who's responsible	Expected changes
	with complex and co-occurring mental health needs.			
2.6c	Develop easy-read guidance to support and encourage people with personal lived experience to find and maintain employment, including advice on human rights and workplace rights, navigating and making the most of workplace supports, disclosure decision-making (such as the SIRA READY decision-making tool), and accountability mechanisms	Short term	National Mental Health Commission Mentally Healthy Workplace Alliance	Increased proportion of people with personal lived experience in employment
2.6d	Expand on the existing Lived Experience (Peer) Workforce Development Guidelines to develop a resource for employers to identify preconditions for success, indicators of organisational and sector readiness, and benefits of a scaled-up Lived Experience workforce. In cases of organisational readiness, embed Lived Experience workforce roles within organisations, and/or foster 'peer champions' in existing roles, to promote positive visibility of lived experience	Medium term	Australian Government Employers	Increase in number of Lived Experience workforce opportunities available
2.6e	Build capacity to provide advice and support for employers to introduce and implement policies and procedures that link to broader strategic and operational plans to create safe, inclusive, non-stigmatising and mentally healthy workplaces, including training, support tools for people with personal lived experience (such as staying/returning to work plans)	Medium term	Australian Government Employers Business and industry peak bodies	Increased proportion of people with personal lived experience in employment Decrease in prevalence and experiences of stigma and discrimination in the workplace
2.6f	Develop resources for use by employers and employees in a range of contexts that provide examples of different types of reasonable adjustments for diverse mental health needs	Medium term	Australian Government	Decrease in number of complaints under federal, state and territory legislation relating to failure to provide reasonable adjustments
2.6g	Review the intersection of legislation, regulation and accountability mechanisms relating to mental health in	Long term	Australian, state and territory Governments	Enhanced alignment between work health and safety legislation

Ref	Action	Timeframe	Who’s responsible	Expected changes
	the workplace (including workplace health and safety, anti-discrimination provisions, workers compensation, industrial relations and privacy) with the objective of identifying options for more equitable access to protections, streamlining regulatory arrangements, clearer understandings of rights and responsibilities and the provision of information and advice for employees with personal lived experience and employers.			and anti-discrimination legislation

2.7 Improve mental health capabilities and supports in education and training settings

Structural discrimination in education settings towards people with personal lived experience acts as a barrier to employment opportunities, financial security, social inclusion and wellbeing. As participation in education carries the potential to break the cycle of poverty – for which mental ill--health itself is a risk factor – it is crucial to address structural discrimination in education settings to ensure equal opportunity and prevent disadvantage from being further entrenched.

Building mental health literacy of staff in educational institutions

Young people in Australia are the cohort most likely to have experienced recent mental ill-health, particularly in high school-aged young people, and many lack the support of an adult carer.[217 218 219] Exposure to education among this cohort makes schools a key setting for stigma reduction, via staff who are knowledgeable about mental health and who actively work to challenge discriminatory treatment.

A 2014 survey found that disclosure of mental ill-health to teachers or lecturers was associated with discrimination, with those who had previously experienced past discrimination in education were more likely to avoid entering into future education and training.[220,221]

Education for staff in educational institutions (including primary, secondary, universities and TAFEs) provides an opportunity to challenge stereotypes and stigmatising beliefs that underpin discriminatory behaviour towards students (and colleagues) with personal lived experience. While principals or institutional leadership are responsible for establishing educational culture and approving learning initiatives, all staff members carry some responsibilities for learning and development around mental health literacy and stigma reduction. Any

A recent Australian survey found:

Half of respondents with lived experience stopped themselves from starting educational courses because of past experiences with stigma and discrimination in education

One in five respondents with lived experience of schizophrenia reported negative experiences in education settings

Source: BETA Baseline Survey Exploratory Analysis new or existing school-based programs [222] should include an explicitly anti-stigma focus.

All educators working with young people should be trained and equipped to identify and work with children with complex needs that may be related to mental ill-health, rather than a focus on managing behaviour which may be stigmatising or result in discriminatory treatment. Mental health literacy training should focus on improving understanding of mental ill-health in young people and identifying opportunities for early intervention, highlighting ways to engage with diverse cohorts (e.g. LGBTIQA+ and neurodiverse people).[223]

Training for staff in the education setting is reliant on sufficient funding available for professional development and support. Therefore, training and development needs should be supported by specific Australian Government funding, with state and territory governments involved in setting minimum requirements, launching training initiatives at scale and providing quality assurance. To deliver the above training initiatives, use of third-party education providers could be scaled up to shift some of the burden of labour for school staff.

Education and training systems share some responsibility for reducing stigma and discrimination, by incorporating mental health literacy into mandatory pre-career training and ongoing professional development. There is an opportunity to leverage current modifications to qualifications frameworks to make mental health training mandatory for trainers and assessors. [224]

Ensure institutional policies support a stigma-free educational environment

Legally binding *Disability Standards for Education 2005* details rights and responsibilities around equal access and opportunity for people with a disability in education settings.[225] These must be underpinned by institutional policies that actively support a stigma-free environment. Policies should be reviewed and developed through a collaborative process alongside people with personal lived experience and support people, and recognise and respond to the diversity of needs among the student cohort.

Common experiences of discrimination in education settings include exclusion from mainstream activities or from classrooms, and being denied leniency or special consideration required due to personal lived experience.[226,227] These institutional failures can have potentially lifelong consequences for young people, presenting barriers to further education and employment opportunities. Certain cohorts of young people are disproportionately affected, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, and young people at transitional stages of education, such as international students.

Aspects of institutional policies that enable stigma reduction include:[228]

- embedding a wellbeing focus to ensure educational institutions are mentally healthy environments, led from the top-down and across the whole learning community
- programs of special consideration and other accommodations that are accessible for all students, actively promoted to both students and staff, and with no undue barriers to the use of reasonable accommodations
- mechanisms in place that empower students to make complaints in the case that reasonable accommodations are not implemented as requested
- mechanisms to enforce anti-discrimination policy, including disciplinary action where policy is found to be breached

- specific roles for Welfare Officers or student engagement staff members, who provide support and advocacy for students with personal lived experience in navigating the institution and liaising with other staff.

Adequate funding is a requirement for the provision of adequate reasonable accommodations, and to support the implementation and ongoing administration of wellbeing programs and accountability mechanisms.

> *“It shouldn’t have to be asked for. These should be blanket options for everyone - arrangements for exams, low sensory spaces should be freely available, not as a secret code that you need to unlock to get help.”*

WORKSHOP PARTICIPANT

Priority actions for education and training settings

Priority actions to improve mental health capabilities and supports in education and training settings are listed in the table below.

Ref	Action	Timeframe	Who’s responsible	Expected changes
2.7a	Conduct research to collect population-level data on prevalence of structural stigma and discrimination against people with personal lived experience in education and training	Short term	National Mental Health Commission	Deeper understanding of prevalence of structural stigma and discrimination in education and training
2.7b	Conduct mental health education programs for students that embed lived experience stories to challenge stereotypes around mental health. Consider opportunities to deliver these through contact-based or peer modelling approaches	Short term	State and territory governments	Decrease in prevalence of stigma and discrimination in education and training
2.7c	Review and where necessary update institutional policies, procedures and practice to embed: • a wellbeing focus across the learning community • special consideration and other accommodations • policies which do not unduly reduce access to accommodations • complaints mechanisms that are enforceable by disciplinary action	Short term	Primary, secondary and tertiary educational institutions Australian, state and territory governments	Decrease in prevalence of stigma and discrimination in education and training

Ref	Action	Timeframe	Who's responsible	Expected changes
	Consider trialling or implementing a specific role for mental health engagement person to support and advocate for students with personal lived experience			
2.7d	Ensure in-school mental health programs contain an explicit anti-stigma focus and include the impact of co-occurring conditions	Short term	National Mental Health Commission	School-based programs include a focus on anti-stigma
2.7e	Support all staff in education and training settings to undertake mental health literacy and stigma-reduction training, using a 'whole learning community approach' to build an inclusive learning environment	Medium term	Primary, secondary and tertiary educational institutions	Increase in uptake of training programs aimed at educational institutions, as shown by mapping analysis of school districts
2.7f	Embed concepts of social and emotional wellbeing and resilience into educational standards at a national level, for jurisdictions to implement into curricula from primary school onwards	Medium term	Australian, state and territory Governments	Decrease in prevalence of stigma and discrimination in education and training
2.7g	Initiate steps to incorporate mental health literacy, with an explicit anti-stigma focus, into pre-career standards, qualifications and ongoing professional development	Long term	Australian, state and territory governments	Increase in proportion of educators and graduates who have completed mental health literacy training

Priority 3: Reduce public stigma

Stigmatising thoughts, feelings, and behaviours among members of the public have profoundly negative impacts on people with personal lived experience and those around them. This is why reducing public stigma is so important.

Public stigma is constituted by negative thoughts, feelings and behaviours held or expressed by individuals towards people who experience mental ill-health.[229]

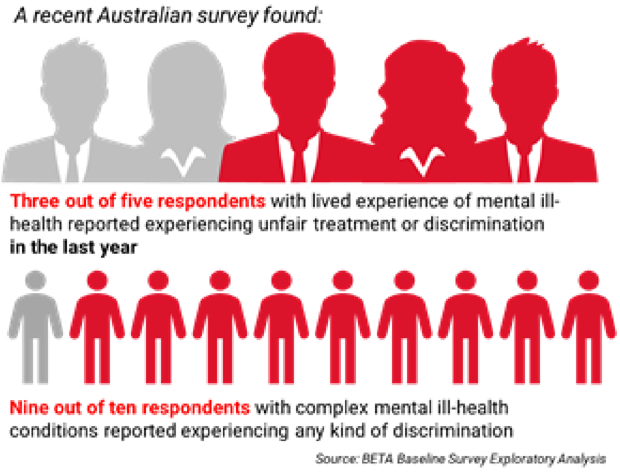
As a result of public stigma, people living with mental ill-health are negatively categorised, othered, and lose status and power in society.[230] This leads to widespread discrimination against people with mental ill-health, which limits a range of life opportunities.[231]

Public stigma is pervasive throughout Australian society. The majority of people with personal lived experience report experiences of public stigma, with those with complex mental health needs reporting more frequent experiences of stigma and discrimination.[232]

Public stigma is not expressed uniformly across all members of the public. Members of the public have differing stigmatised responses to various aspects of mental ill-health, from signs and symptoms of ill-health, to clinical or diagnostic labels, to help-seeking and treatment participation.[233] Different social groups stigmatise mental ill-health in different ways and to different degrees.[234]

There is a clear need to address stigmatising attitudes and discriminatory behaviours. Changing attitudes among members of the public is not sufficient. Discrimination will continue unless the behaviours that impact people with personal lived experience are also changed. Every member of the Australian public has a role to play in eliminating public stigma from our society.

Stigma and discrimination represent a fundamental human rights issue, because they negatively impact on the ability of people with lived experience to experience respect and equal dignity and live long and contributing lives. Past approaches to reducing public stigma have, on the whole, failed to incorporate a framing which reflects the human rights of people with personal lived experience, or the responsibility of governments and the community to respect their human rights. There remains a need to increase public understanding of mental health-related stigma and discrimination as a human rights issue.



A recent Australian survey found:

Three out of five respondents with lived experience of mental ill-health reported experiencing unfair treatment or discrimination **in the last year**

Nine out of ten respondents with complex mental ill-health conditions reported experiencing any kind of discrimination

Source: BETA Baseline Survey Exploratory Analysis

3.1 Build a social movement to catalyse community action to reduce stigma and discrimination

Existing strategies in Australia have largely used generalist, education-based approaches to reframe public attitudes around mental health. This includes universal community education, as well as programs that cover mental health in a general sense, targeted toward different settings or groups.[235,236] The effects of existing campaigns have been found to be effective in the short-term, with greater effects on reducing stigma observed the more extensive the initiative.[237] The long term efficacy of one-off campaigns remains unknown.[238]

Some overseas initiatives have sought to eliminate stigma and discrimination by developing social movements, rather than relying on one-off campaigns. These movements are multileveled, with different aspects of the initiative directed to different settings and audiences. Promising examples of social movement approaches (such as the nationwide Noku te Ao in New Zealand and Time to Change in the United Kingdom) are community-led and seek to embed leadership roles for people with lived experience.[239] [240]

Efforts to reduce stigma and discrimination in Australia also need to be multifaceted and enduring, including generalist, contact-based and educational initiatives. This is because different aspects of mental ill-health relate to diverse stereotypes and stigmas among the public and therefore require different responses. Together, these initiatives could drive a social movement which confronts and eliminates stigmatising attitudes and behaviours among the Australian public.

Build on success factors for public stigma reduction initiatives

Critically, people with personal lived experience must be empowered to play meaningful roles in all aspects of any stigma reduction efforts.[241] Initiatives should be both informed by and tailored towards their diverse perspectives, experiences, and choices. This would allow public stigma reduction efforts to represent and amplify a broad spectrum of experience, recognising these can be very different between individuals with personal lived experience and their families and support people. It would also enable initiatives to directly address stereotypes associated with less common diagnoses and more complex mental health needs. To successfully embed lived experience voices into public stigma reduction approaches, public barriers to people with lived experience must be eliminated.

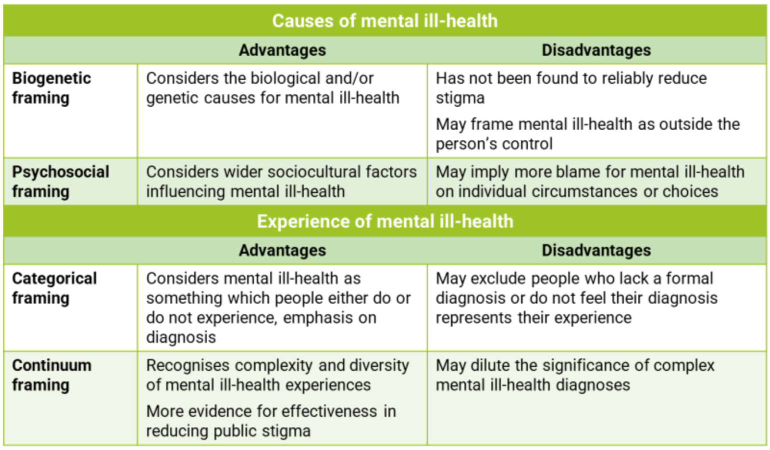
The way public stigma is formed and expressed is highly complex and varied. This means that eliminating public stigma needs equally complex approaches that move beyond purely informing the public about mental health. There is an ongoing need for effective, generalised campaigns which build the mental health literacy and understanding of the public. Human rights need to be a central frame of reference, as these provide a powerful tool through which stigmatising and discriminatory attitudes and behaviours may be identified explained and challenged.

Traditional media channels have been shown to be an effective means of reaching rural and remote populations, as well as culturally and linguistically diverse communities. Meanwhile, social media initiatives remain an important complement which can target priority groups, including young people, and provides a platform for promoting key messages which can contribute to a sustained social movement. To achieve maximum reach, a blend of platforms should be used.

Messaging strategies and framing are important to consider. There are disadvantages to framing mental health as being purely due to biogenetic factors or psychosocial factors (see Table 1).[242,243] Similarly, categorical (diagnosis-based) framing of mental ill-health contrasts with continuum-based framing, which conveys more complexity and diversity of mental ill-health experiences. Continuum messaging shows more promise in reducing public stigma and even improving public attitudes, but if used in isolation runs the risk of undermining the significance of complex mental health diagnoses for many individuals. [244]

Using a combination of these framing and messaging strategies, as well as involving people with lived experience in the design of messaging strategies, are potential ways of overcoming unintended consequences of any one messaging strategy. In particular, co-design with people with lived experience may transcend these styles of framing and their limitations. Human rights framing and drawing on the social model of disability are also integral to all messaging intended to reduce public stigma.

Table 1: Advantages and disadvantages of messaging strategies



Causes of mental ill-health		
	Advantages	**Disadvantages**
Biogenetic framing	Considers the biological and/or genetic causes for mental ill-health	Has not been found to reliably reduce stigma May frame mental ill-health as outside the person's control
Psychosocial framing	Considers wider sociocultural factors influencing mental ill-health	May imply more blame for mental ill-health on individual circumstances or choices
Experience of mental ill-health		
	Advantages	**Disadvantages**
Categorical framing	Considers mental ill-health as something which people either do or do not experience, emphasis on diagnosis	May exclude people who lack a formal diagnosis or do not feel their diagnosis represents their experience
Continuum framing	Recognises complexity and diversity of mental ill-health experiences More evidence for effectiveness in reducing public stigma	May dilute the significance of complex mental ill-health diagnoses

There are known gaps around intersectional understandings of mental ill-health in current public campaigns. To date, there has been a limited focus on the multiple intersecting forms of disadvantage, discrimination and stigma people may experience for reasons outside of mental ill-health alone. Similarly, public stigma reduction initiatives need to address the impact of structural forms of stigma of internalised/self-stigma, which has been a key limitation in the effectiveness of efforts to date.[245,246]

Similarly, although previous stigma-reduction programs have had some success in reducing stigma towards depression and anxiety, stigma towards less common conditions has not decreased, and has actually increased in some instances.[247,248] People with complex mental health needs are a key priority area for future public stigma reduction initiatives. These gaps should be resolved through incorporating more diverse voices in the design and leadership of stigma-reduction initiatives, reconsidering the framing of mental ill-health to take a broader, rights-based lens, and incorporating contact-based approaches (see below).

Addressing and preventing public stigma takes a long time, with sustained effort required to build positive relationships and a level of familiarity necessary to reduce stigmatising attitudes and discriminatory behaviours toward people with personal lived experience. Contact-based and education-based approaches to reducing public stigma ultimately need to be enduring and sufficiently resourced to reach greater segments of the Australian population, which have been key limitations of broad-based public stigma reduction initiatives to date. The evidence base around public stigma, and the effectiveness of public stigma reduction initiatives, should be improved through an ongoing evaluation strategy (see *1.4 Improve the evidence base through data collection and evaluation*).

Increase public contact with and empathy for people with personal lived experience

A contact-based approach is a key aspect of a hybrid, layered and enduring social movement. This approach places lived experience at its core, empowering people with personal lived experience to play a meaningful role in public stigma reduction. Improving public knowledge and understanding of the diversity of personal experiences of mental ill-health is the underlying rationale of contact-based approaches to stigma reduction.[249]

Contact-based initiatives should be made available and accessible for more members of the public, particularly for people with limited familiarity with mental ill-health experiences. These initiatives should seek to build empathy and shared trust, incorporating narratives that highlight the strengths of people with personal lived experience and the significance of recognising and respecting their human rights.

Contact-based approaches involve members of the public observing or interacting with an individual who lives with mental ill-health.[250] Examples of these can include presentations in settings like workplaces, music, arts, and community events such as The Big Anxiety, Schizy Inc events, MAD Poetry, and Listening to Voices performances.

Contact-based approaches work to build familiarity through shared experiences of mental ill-health and treatment, which evidence shows is even more important for stigma-reduction than knowledge of signs, symptoms or their impacts. Increasing intimacy of connections can have a moderating effect on the level of public stigma held by the individual.[251] This carries implications for stigma and discrimination at the hands of family, support people, mental health workers and other health professionals, who have close contact with people with direct lived experience.[252]

Contact-based stigma reduction programs also have the ability to target diverse populations, and enable focussed messaging that emphasises specific and relevant elements of mental ill-health experiences and stigma.[253]sustained and targeted contact-based. For this reason, sustained and targeted contact-based approaches are an important complement to larger-scale, population-based campaigns. Opportunities for contact-based initiatives include leveraging culturally appropriate arts and creative practices, food and sporting organisations and events. In particular, stigma reduction initiatives should be offered to the following groups:

- Family, friends, and support people, who can be encouraged to build familiarity through emphasising shared experiences[254]

- Groups that have historically contributed to discrimination of people with personal lived experience, including people in positions of authority and power in society (e.g. health professionals, police, defence force and the media)

- People in current and future roles which out them in frequent contact with people with personal lived experience, and may have historically contributed to stigma and discrimination (including health and care workers, child protection workers, and people in HR roles), who may be targeted through workplace or educational settings[255]

- Aboriginal and Torres Strait Islander communities, with culturally appropriate, sustained stigma reduction initiatives being designed and delivered by community members with lived experience[256,257]

- Culturally and linguistically diverse communities, in which initiatives should “incorporate culturally appropriate understandings of mental health and social and emotional wellbeing, be delivered in a range of community languages, be community-led, and engage community leaders in design, delivery and evaluation.” [258,259,260]

- Gender-based groups and young people at-risk of mental ill-health (including young men)[261]

- LGBTIQA+ people.

It is essential that contact-based strategies are mutually beneficial for both participants and the person with lived experience. Organisations delivering contact-based approaches need to ensure the work is seen as valuable, legitimate, and paid fairly. Embedding lived experience voices more broadly across key settings (i.e. where the contact-based approaches would be delivered) would support this.

Education initiatives for two key priority groups, health professionals and young people in education settings, will be discussed further in the following section.

Establish education initiatives to reduce public stigma

Education initiatives provide an opportunity to introduce and reinforce positive strengths-based messaging about mental health and ill-health, centring the conversation around lived experience to promote positive narratives of hope and recovery. While education campaigns have been used in the past, there is an opportunity for them to have a more explicit anti-stigma focus (rather than, for example, focussing on increasing help-seeking behaviour, or using general mental health literacy programs for the purpose of stigma reduction). Delivery of these initiatives should prioritise education-based and health settings in order to capture key audiences. Education initiatives have the potential to not only reduce public stigma, but also structural stigma (when applied in key cohorts who hold institutional power) and self-stigma.

Mental health education for students

School-based initiatives are a key element in the social movement to reduce public stigma. Evidence has shown stigma reduction initiatives have had success in targeting young people.[2628] Providing robust education from early in life and throughout the education system serves to create generational change in attitudes, preventing stigma and discrimination from being reproduced as subsequent generations move from education into the workforce (including key roles in institutions targeted for reducing structural stigma).

Although educational institutions can be settings for discrimination, Australian survey data indicates schools are also, often, environments where people with personal lived experience received positive treatment. This indicates the importance of educational environments as settings of support.[263] Therefore, school-based education about mental illness is an important opportunity to address stigmatising attitudes, particularly those with complex mental health needs or diagnoses that are less well-understood.

Concepts of mental, social and emotional wellbeing and resilience can be embedded into curricula in primary school, secondary and tertiary settings. Contact-based approaches, such as lived experience narratives and peer modelling in education settings, are ways of empowering young people to move beyond awareness to develop empathy and understanding around mental ill-health. This serves to normalise mental ill-health and give young people concrete tools to manage their own mental health, whilst challenging stereotypes among peers and staff. [264] Educational approaches should be based on pedagogical approaches and be evaluated for effectiveness in terms of reducing stigmatising attitudes and behaviours.

Examples of programs with potential to reduce stigmatising attitudes among school communities:

- Teen Mental Health First Aid (tMHFA) has been established to reduce stigmatising attitudes among secondary school students.[265] Delivered in high schools, its aim is to upskill teens in recognising and responding to mental health problems among peers.

- A range of free resources offered by Black Dog Institute are aimed at school-aged students, including presentations delivered by people with lived experience. These may lend themselves to stigma reduction through contact-based approaches.

- batyr@school programs which utilise peer to peer storytelling to encourage help-seeking and to give students tools and knowledge around how to manage their mental health or support a friend.

- Frameworks such as Be You which endorse a ‘whole learning community approach’ to creating mentally healthy educational environments.

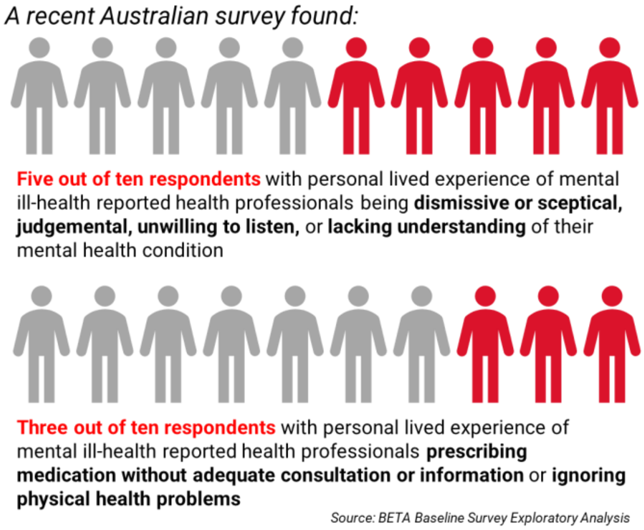
A review of existing interventions found tertiary institutions are among the most common settings for anti-stigma programs, with fewer delivered in high schools and very few programs to date being run in primary schools. This indicates potential underutilised opportunities for age-appropriate, early intervention to reduce stigma. Mental health education is particularly important to offer in non-mainstream education settings where students may be particularly vulnerable – such as English Language Intensive Courses for Overseas Students (ELICOS).[266]

It is important that mental health education is accompanied by genuine institutional support for students with personal lived experience – and that the use of these supports is understood and normalised. Training to improve the mental health literacy of staff, and institutional policies which eliminate discriminatory practices, are important underpinnings (see *2.7 Improve mental health capabilities and supports in education and training settings*).

Stigma reduction education for mental health professionals

Current stigma reduction initiatives have effectively targeted current and future mental health workers through education initiatives, and there will be a need to scale up these efforts to respond to stigma and discrimination in the mental health system.[267] These initiatives have a significant potential impact because of the high level of engagement between people with personal lived experience and the mental health workforce.

Where mental health professionals hold stigmatising attitudes towards the people seeking care, this can have an impact on their access to care and the quality of care provided. Negative interactions with mental health professionals can interrupt the continuity of care for people with personal lived experience, and can result in people avoiding getting help or engaging with their care. Stigmatising attitudes of mental health professionals can also impact support people.



A recent Australian survey found:

Five out of ten respondents with personal lived experience of mental ill-health reported health professionals being **dismissive or sceptical, judgemental, unwilling to listen,** or **lacking understanding** of their mental health condition

Three out of ten respondents with personal lived experience of mental ill-health reported health professionals **prescribing medication without adequate consultation or information** or **ignoring physical health problems**

Source: BETA Baseline Survey Exploratory Analysis

A 2021 survey found around one in four people with recent experience of mental ill-health reported being treated unfairly by a health professional when getting help for a mental health problem. Of these respondents, the most common profession identified was GPs (by 63 per cent of respondents reporting unfair treatment), followed by psychologists (35 per cent) and nurses (16 per cent). People living with personality disorders, eating disorders, trauma and dissociative disorders are the most frequently impacted by stigma and discrimination in mental health settings. [268]

It is important that education initiatives engage the people and institutions involved in training, supervising, and upskilling the mental health workforce (including universities, TAFEs, professional bodies, and associated regulatory/accreditation bodies). Currently, the inclusion of content on stigma in mental health courses or learning activities is at the discretion of individual faculty members and their level of personal knowledge and engagement with stigma reduction. There are various bodies that provide accreditation for higher education curriculum and training standards for health professionals that specify the knowledge and skills students should have upon graduating. There is an opportunity for accreditation bodies to stipulate that courses must include content around stigma, which would have the potential to reduce stigmatising attitudes and behaviours among clinicians in the profession. Any such training should include components around intersectional and compounding experiences of stigma, including for people with different diagnoses and experiences of mental ill health (especially people with complex mental health needs) as well as for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.[269,270]

Mental health education programs should also consider embedding contact-based learning, delivered by lived experience speakers (e.g. through external organisations, or partners working within the profession). Within mental health workplaces, Lived Experience workers already embedded in the organisation can play a key role in the delivery of learning content. Within all workplaces and educational institutions, peer champions can also be internally selected to role model non-stigmatising attitudes and normalising discussions about mental health.

People working to deliver the NDIS (including planners and Local Area Coordinators) and NDIS-funded supports are a further target cohort for education initiatives, with a particular focus on psychosocial disability related to mental ill-health. As also acknowledged by a recent evaluation report training should include contact-based initiatives developed and delivered by people with personal lived experience of disability[271] as well as components with an explicit anti-stigma focus.

Priority actions to build a social movement

Priority actions to build a social movement to catalyse community action to reduce stigma and discrimination are listed in the table below. Note that where evidence-based initiatives already exist, the associated action should be read as increasing funding to build on these approaches and strengthen evaluation of impacts.

Ref	Action	Timeframe	Who's responsible	Expected changes
3.1a	Design and implement appropriately tailored and culturally-safe hybrid educational and contact-based training initiatives (with a rights-based framing) within primary, secondary and tertiary education settings	Short term	National Mental Health Commission	Decrease in prevalence of stigma and discrimination in education settings and longer term across the population
3.1b	Design and implement appropriately tailored and culturally-safe hybrid educational and contact-based training initiatives (with a rights-based framing) for people in frequent contact with people with personal lived experience, including:	Short term	National Mental Health Commission, working with relevant peak bodies, professional associations, regulators, educational institutions and	Decrease in prevalence of stigma and discrimination in settings with frequent contact with people with personal lived experience

Ref	Action	Timeframe	Who's responsible	Expected changes
	• mental health workers (including NDIS administrators, service providers and other employees) • health workers • social services workers • child protection workers • teachers and early childhood educators • police • people working in legal and financial systems • Managers, supervisors and people in HR roles As part of this, embed informal and formal Lived Experience roles in leadership and support roles throughout organisations		employer associations	
3.1c	Design and prototype/pilot appropriately tailored and culturally-safe contact-based initiatives (with a rights-based framing) in collaboration with key communities: • Aboriginal and Torres Strait communities • CALD communities • LGBTIQA+ people • Family, friends and support people • Specific gender and age groups (e.g. young men) Initiatives to be prototyped/ implemented should: • be created by people with lived experience • test different messaging strategies and be delivered in different ways, including social media and traditional media • use a strengths-based narrative and aim to normalise speaking about mental health in daily life • leverage culturally appropriate arts and other creative practices, food and sporting organisations and events	Short term	National Mental Health Commission	Improved attitudes toward people with personal lived experience among target populations Reduction in mental health-related stigma and discrimination among priority populations

Ref	Action	Timeframe	Who's responsible	Expected changes
	• invest in and promote the full spectrum of work currently performed by lived experience speakers and organisations, and provide new opportunities for community members to contribute • be rigorously evaluated before scaling up.			
3.1d	Specify that professional mental health education and training (pre-service and ongoing professional development) must include content about rights-based approaches to mental health care, valuing lived experience and the impact of stigma and discrimination (including diverse and compounding experiences of stigma and discrimination) in their curricula	Medium term	Relevant higher education training and accreditation bodies	Improved attitudes toward people with personal lived experience among mental health workers Reduction in stigma and discrimination in mental health settings
3.1e	Ensure all future public stigma reduction initiatives: • incorporate human rights in the frame of reference • use a strengths-based narrative that emphasises hope and recovery, and expresses the many and varied ways that people with personal lived experience contribute to the community • are co-designed and implemented by people with lived experience • consider how people are affected who experience multiple forms of discrimination	Medium term	National Mental Health Commission	Sentiment of public stigma reduction materials and communications Deeper understanding of intersectionality related to mental ill-health among audiences

3.2 Improve the quality of media reporting and representations of mental ill-health

The media has a strong influence over the public's beliefs and attitudes toward, and responses to, people with personal lived experience. This means that the way people with personal lived experience and their families and support people are portrayed in the media can reinforce negative stereotypes and myths that drive stigma and discrimination. [272]

Positive and nuanced representations of people experiencing distress and mental ill-health in mass media

The link between the media's portrayal of mental ill-health and stigma and discrimination is well established.[273] [274] In Australia, a survey of people with complex mental health needs revealed that over 40 per cent of respondents experienced ‘mass media’ as one of the key domains in which they had been most affected by stigma in the last 12 months. Respondents described hurtful or offensive portrayals of mental ill-health in the media, with the media reported to ascribe links to violent, unsafe or criminal behaviour, or to blame people for their mental ill-health. [275] Other problematic representations in mass media coverage include overly simplistic narratives of people with personal lived experience either as victims or as sources of inspiration, stereotypical portrayals of treatment and recovery, and blame for mental health system failings.[276,277]

Negative news stories can encourage stigmatised attitudes, while positive news stories about mental ill-health can lead to reductions in stigmatising attitudes.[278] This highlights the potential benefits of targeting the mass media in public stigma reduction efforts. While media reporting guidelines for the reporting of various experiences of mental ill-health do exist in Australia,[279] they are not required to be followed by law. All media providers should adopt key policies which bring their reporting in line with these guidelines, which uphold the human rights of people with lived experience. The guidelines themselves require stronger accountability mechanisms to be attached, which ensure breaches are met with appropriate consequences for the broadcaster.

Because both traditional and social media platforms are intended be leveraged in a social movement to reduce public stigma, all employees of mainstream and emerging social media outlets should be considered a key audience for stigma reduction initiatives. However, there is limited evidence of the effectiveness of strategies aimed at journalists and journalism students in the Australian context.[280]

People with experiences of less common and more complex mental health needs, who are more likely to be impacted by negative media portrayals, would benefit from targeted strategies aimed at the role of media in reducing stigma and discrimination. People with these experiences report that media depictions of mental health issues that were accurate, sensitive, taken seriously and promoted hope were beneficial.[281] Celebrities or sportspeople sharing their personal lived experience in the media are received positively, although these experiences ultimately do not represent the experiences of all people with personal lived experience.[282]

People who experience multiple, intersectional layers of stigma and discrimination, including population groups that typically experience negative media portrayal due to factors or attributes other than mental health status (e.g., Aboriginal and Torres Strait Islander people and people from cultural and linguistically diverse backgrounds[283]), would also benefit from targeted media reform strategies. Based on the extent of negative media portrayals of mental ill-health in the context of violent crime, this is also clearly an area of news reporting that requires targeted strategies to improve.

Strengthen oversight and accountability of social and other non-mainstream media

Stigma and discrimination are also pervasive on social media platforms. One in four surveyed people with complex mental health needs identified social media as one of the top three domains where they experienced stigma and discrimination in the last year and reported these experiences slightly more frequently than the average respondent.[284] These experiences of stigma and discrimination include engaging with content, and engaging with other social media users. Digital and social media presents challenges as it is less regulated than mass media and is a setting where stigmatising attitudes and bullying or ‘trolling’ behaviour can be allowed to proliferate.[285]

There are calls for stronger oversight and accountability of media outlets and professionals regarding portrayals of mental ill-health that may encourage stigma and discrimination in the public.[286] This is particularly important because social media (as with other emerging media sources) is a key platform for reaching the widest possible audience for public stigma reduction efforts, such as young people. All digital media platform providers should adopt key policies around content moderation that protects human rights of social media users with personal lived experience. In addition to codes of conduct on individual platforms, innovative models include multi-stakeholder accountability mechanisms, in which social media platforms participate on a voluntary basis.[287] [288]

Priority actions for media settings

Priority actions to improve the quality of media reporting and representations of mental ill-health are listed in the table below.

Ref	Action	Timeframe	Who's responsible	Expected changes
3.2a	Improve the mental health literacy of media professionals and students (including human rights literacy) through expanded targeted training which include contact-based components and hybrid messaging strategies (see *Priority 1* for detail)	Short term	Australian Government Educational institutions Broadcasters, content developers and media industry bodies	Decrease in number of complaints of breaches of advertising / media standards relating to mental health-related stigma and discrimination
3.2b	Explore options for increasing the diverse representation of mental ill-health in broadcast media, such as considering the role of content quotas	Short term	Australian Government, working closely with media industry bodies, including regulatory and representative organisations	Decrease in number of complaints of breaches of advertising / media standards relating to mental health-related stigma and discrimination
3.2c	Promote education and collaboration between people working across all forms of media (including industry bodies, creative media and artists) with the mental health sector (including lived experience advocates) with a focus on stigma reduction, through: • improved adherence and accountability against existing media standards • improved practices of covering news stories and portraying individuals in mental distress • opportunities for more positive mental health stories.	Medium term	Australian Government, working closely with media industry bodies	Decrease in number of complaints of breaches of advertising / media standards relating to mental health-related stigma and discrimination

Ref	Action	Timeframe	Who's responsible	Expected changes
3.2d	Use media channels and digital platforms to prevent stigmatising attitudes from developing, by: • introducing segments on children's television programs that can start to appropriately introduce concepts of mental health, including rights-based concepts, and diversity of experiences from a young age. • forming partnerships with large commercial media platforms and outlets to develop and implement a shared vision around mental health-related stigma and discrimination	Medium term	National broadcasters and major commercial networks, including streaming platforms	Decrease in prevalence of stigmatising attitudes toward people with personal lived experience among audiences
3.2e	Conduct scoping for a voluntary multi-stakeholder accountability mechanism for digital platforms, to review content moderation and terms of service and identify and implement actions to reduce stigma and discrimination	Medium term	Office of the eSafety Commissioner Digital platforms	Decrease in prevalence of stigmatising portrayals of people with personal lived experience across social media
3.2f	Influence digital platforms to moderate content that promotes or reinforces mental health-related stigma and discrimination	Medium term	Office of the eSafety Commissioner Digital platforms	Evidence of moderation policies of social media platforms
3.2g	Undertake work to increase online literacy, safety and respectful online behaviour, including amongst key public figures, to improve understanding of mental ill-health and human rights and how to use platforms to reduce stigma and discrimination	Short term	Office of the eSafety Commissioner	Increase in positive sentiment of social media content produced and shared by targeted influencers and celebrities
3.2h	Develop and implement campaigns using mass media and digital platforms that: • move beyond a focus on the scale of the problem and what not to do, to incorporate suggestions for engendering hope, positive language and behaviours towards people with personal lived experience, and respect for their dignity and rights • reach rural and culturally and linguistically diverse communities (e.g., through funding CALD radio and organisations in each state to	Medium term	Australian, state, territory, and local governments	Decrease in prevalence of stigmatising portrayals of people with personal lived experience in mass and social media campaigns

Ref	Action	Timeframe	Who’s responsible	Expected changes
	lead action connected with established lived experience perspectives) - are co-designed and co-delivered with people with lived experience			

Priority 4: Reduce self-stigma

Mental health-related self-stigma is a complex, nuanced, highly personal experience, deeply felt by some people with personal lived experience. Self-stigma can impact self-esteem, identity and lead to withdrawal or avoidance when people with personal lived experience become aware of, internalise, and/or come to expect negative experiences with public and structural stigma.

Self-stigma is the process in which a person with personal lived experience becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to the self. The person comes to believe these negative messages or stereotypes about mental ill-health and applies these to themself.[289]

Self-stigma is associated with an awareness of stigmatising attitudes, prejudice, stereotypes, and discrimination against people with personal lived experience (perceived stigma), leading to a fear of experiencing stigma in the future (anticipated stigma). This may cause withdrawal from opportunities, negative self-belief, and reduced self-esteem.[290] These factors in turn can discourage help-seeking and/or reduce the effectiveness of support.[291] Experiences of self-stigma are diverse among people with personal lived experience and their families and support people. The way people experience self-stigma has a complex interaction with their social and cultural environment, and for some, with their symptoms of mental ill-health. It should be noted that some people with personal lived experience have never experienced self-stigma.

Perceived stigma is a person's awareness or perception that the public holds prejudice, negative views or engages in discriminatory behaviour towards people who experience mental ill-health.

Anticipated stigma is a fear that prejudice, discrimination and stereotyping will be directed at the self from others in the future. The experience of perceived stigma is central to anticipated stigma, and often results in withdrawal from opportunities.

Evidence shows that people who have been exposed to mental health-related discrimination are more likely to develop self-stigma.[292] Self-stigma therefore cannot be addressed without overarching actions to reduce public and structural stigma and discrimination. The potential wellbeing impacts of self-stigma make it important to address as an outcome of public and structural stigma, with further research also required into specific self-stigma-reduction initiatives.

Because self-stigma, like mental health itself, is a complex highly personal experience, it can be challenging to conceptualise and to address. Building the evidence base around self-stigma reduction is a priority, in order to explore options for using broader stigma-reduction initiatives to address self-stigma.

A recent Australian survey found:

Around half of respondents with lived experience of mental ill-health held self-stigmatising sentiments such as ***"I should be able to pull myself together"*** and ***"I feel like a burden to other people"***

Source: BETA Baseline Survey Exploratory Analysis

4.1 Address self-stigma through public stigma reduction initiatives

Self-stigma can develop through a person's own experience, their social and cultural environment, and underlying attitudes held by themselves or their community. These factors may intersect with people's experiences of stigma and discrimination at different points during their interactions with society's structures, including the health and mental health systems, which may introduce or reinforce negative and stigmatising beliefs about mental ill-health. This means individual experiences of self-stigma, and their causes, vary greatly.

Self-stigma among Aboriginal and Torres Strait Islander people can be experienced as a more pronounced sense of shame, derived from cultural beliefs around mental ill-health as resulting from personal flaws or cultural wrongdoing (a form of public stigma). This may be exacerbated when Australia's society and structures lack understanding and dismiss non-clinical, relational aspects of mental health, such as connection to country, kinship and culture. Specific and targeted community-led initiatives are the most appropriate way to address stigma, including self-stigma.

Because self-stigma is strongly related to broader structural and public forms of stigma, over which the individual has very limited control, it cannot be effectively addressed in isolation. At the whole-of-population level, best practice self-stigma reduction interventions seek to reduce self-stigma by targeting public and societal institutions. Changing public and institutional attitudes and behaviours can break down and limit exposure to stigmatising attitudes, preventing these from becoming internalised.

The same core stigma reduction principles are also key to reducing self-stigma. Embedding lived experience engagement and participation in the mental health system can foster emotional wellbeing and self-confidence, in addition to breaking down stigma.[293] Self-efficacy[k] can be improved by increasing the participation of people with lived experience in the workforce (in Lived Experience workforce roles or otherwise), education and training or community engagement. Educational programs focused on destigmatising mental ill-health (discussed further in *Establish education initiatives to reduce public stigma)* may contribute to reducing self-stigma among students with personal lived experience by reducing their exposure to public stigma.

Human rights law and a rights-based approach are essential foundations for reducing self-stigma because they protect and reinforce the individual's sense of dignity and agency, whatever the status of their mental health. Human rights simultaneously reflect and shape social norms. They have the power to influence all forms of stigma and discrimination, flowing through to self-stigma. Human rights law grants individuals the agency to claim their right to dignity, and to resist self-stigmatising influences.

Although experiences of self-stigma are highly personal, certain factors may heighten the risk of experiencing self-stigma. Different cultural and community norms, attitudes, and stereotypes around mental ill-health, as well as diverse experiences of co-occurring stigmas, should all inform the way stigma-reduction interventions are delivered. Groups who are most affected by self-stigma, and who should be specifically targeted by interventions, include:

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[k] Self-efficacy is a person's belief and confidence in their own capacity to successful act in specific situations.

- people with complex mental health needs (people diagnosed with psychotic disorders, personality disorders, eating disorders, or with multiple needs), [294] intersecting stigmatised experiences (e.g. co-occurring alcohol or other drug use, gambling harm, financial stress, trauma and/or suicidality[295] [296]) and people experiencing depression and anxiety[297]

- people with lived experience of discrimination, for example, racism, ableism, homophobia, transphobia and/or discrimination related to socioeconomic status[298]

- Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds, for whom mental ill-health may be culturally associated with shame and/or linked to ideas of individual failing[299]

- people involved in the justice system, who may experience a magnified effect of mental health-related self-stigma and perceived criminality. [300]

- health professionals who have personal lived experience

At the individual level, there is emerging evidence for the effectiveness of peer support training programs in developing key skills to reduce self-stigma among people with personal lived experience. Evidence behind these approaches suggests that best practice is group-based, incorporates CBT and mindfulness, and aims to build stigma resistance, resilience, and self-compassion, with a focus on the collective or group experience. Interventions should be strengths-based and emphasise hope, recovery, relapse prevention, self-esteem, self-efficacy and meaning.[301] Further evidence is needed to support the scaling up of similar targeted programs, particularly around limiting potential unintended consequences (including reinforcing self-blame for mental ill-health).

> *"I have a lot of self-stigma, [I] struggle every day. I've found that hearing stories really helps… someone else who's been in this system, sharing solutions. Normalise it by hearing stories in all aspects."*

WORKSHOP PARTICIPANT

4.2 Address self-stigma amongst the Lived Experience workforce

Self-stigma among members of the Lived Experience workforce may impact their wellbeing and ability to perform their role. This includes sections of the Lived Experience workforce with specialisation and lived experience with suicide and alcohol and other drugs. Self-stigma may develop as a result of perceived and anticipated stigma against themself as a person with personal lived experience or as a carer or support person, as a Lived Experience worker (in either a personal Lived Experience role or a family/carer role), or both. The Lived Experience workforce may perceive or experience stigma and discrimination that characterises their role as being of lower-status, and/or exclusion by others.[302] These beliefs may be internalised and reflected as lower self-worth.[303]

Lived Experience workforce roles require supportive working environments to be successful and prevent experiences of self-stigma. This complexity is heightened by the fact that personal Lived Experience workers may also experience self-stigma towards their own mental health (rather than, or in addition to, their role in the Lived Experience workforce).[304] Further difficulties are noted around managing role ambiguity, and often poor accountability for supervision.[305] [306] Training and face-to-face support from experienced peers are important resources for Lived Experience workers which may reduce self-stigma.[92] Other enablers include: [307]

- appropriate supervision for lived experience roles, with a focus on enabling genuine career progression, role-specific training and coaching
- opportunities for formal and informal group discussions with other experienced Lived Experience workers, such as through communities of practice
- structured and interpersonal support in the form of inclusive, whole-of-service approaches to wellness planning for staff (including those outside the Lived Experience workforce)
- availability of self-help interventions and training.

Embedding people with personal lived experience across workforce roles is foundational to reducing all forms of stigma, including self-stigma. This is achieved by increasing public exposure and visibility of people with personal lived experience and the inherent value they bring to society. A rights-based approach, grounded in human rights law, must inform how the Lived Experience workforce is engaged.

Lived Experience workers roles play a vital role in reducing self-stigma and promoting the empowerment of others, with many also experiencing benefits from their role in terms of increased self-worth, fostering hope and recovery outcomes.[308] This highlights the importance of ongoing support for this workforce, including through top-down organisational commitment to embedding diverse lived experience voices, ongoing communication and training to foster collaboration between the Lived Experience workforce and non-peer workforce, and appropriate supervision to foster career progression.[309]

4.3 Introduce measures to reduce self-stigma among support people

A further challenge is posed by self-stigma experienced by support people, including carers, family members and friends. Support people describe regularly experiencing stigma via public attitudes, health professionals and others which whom they come into contact. Common stigmatising beliefs towards support people include blame and shame (attributing the cause of mental ill-health to the support person, particularly where they are a family member), and associated stigma (where the support person experiences stigma vicariously due to their association with somebody with personal lived experience).[310] Self-stigma among support people is associated with social isolation, discrimination and exclusion from societal institutions, with ensuing impacts on their own wellbeing.

The perspectives and input of families, carers and support people, and of people with personal lived experience, should be embedded in self-stigma reduction initiatives. They should also be informed by a rights-based approach grounded in human rights law. Stakeholder consultations indicate an opportunity to embed more peer support from other support people and improve access to educational resources. These supports are reliant on strong ties between consumer and carer advocacy organisations and key institutions. This would equip support people with the advocacy skills to help the people they care for navigate the health system and other institutions.[311]

Around one in four family members of a person with lived experience of mental ill-health reports **lower self-esteem**

Around one in four family members of a person with lived experience of mental ill-health **anticipates blame**

Source: Corrigan 2008

Because the nature of self-stigma is complex and intrinsically tied to experiences of public and structural stigma and discrimination, it cannot be fully addressed without broader stigma-reduction interventions. Systemic underfunding of underlying systems, organisations and programs is a common barrier to support people receiving the resources they need to perform their role and maintain their wellbeing (including respite and peer support). Targeted group-based training programs have been used in some instances (for example, the Family to Family Education Program, widely used in the US), and may incorporate elements of stigma-resistance, self-compassion and resilience-building.[312] However, more evidence is needed for their effectiveness for reducing self-stigma in support people in an Australian context.

Associated stigma is important to address for the wellbeing of families and support people, but also because support people are among those whose attitudes and behaviours have the potential to significantly influence the health and wellbeing of people receiving care or support. It should also be noted that support people may be experiencing mental ill-health (and associated stigma and discrimination) themselves.

4.4 Strengthen evidence base for initiatives to reduce self-stigma

A stronger evidence base is needed around experiences of self-stigma. There are particular opportunities for examining the impact of self-stigma on overall wellbeing and recovery outcomes, and improving the evidence base around effective strategies for reducing self-stigma (both targeted and as an outcome of public and structural stigma-reduction initiatives).

Improved data around self-stigma is needed for the Lived Experience workforce and support people as specific categories. Population-level data (including people who have not disclosed or do not identify as having personal lived experience) should also be collected to improve understanding of the prevalence of self-stigma among the general population.

Although evidence exists for targeted self-stigma-reduction initiatives at an individual or group-based level, further evaluation is needed for programs which directly target self-stigma among people with personal lived experience. In particular, evaluation approaches should seek to interrogate ways to reduce the risk of potential unintended consequences (such as unintentionally reinforcing blame for experiences of mental ill-health, or public or structural stigma). A strengthened evidence base for targeted initiatives should inform decisions around whether to scale up these approaches to reach wider populations. Further evaluation and evidence of effectiveness is particularly warranted for the following types of interventions:[313]

- programs which teach stigma-resistance, resilience and self-compassion in individual or group-based settings, particularly those which target diverse community groups
- self-guided programs (e.g. online therapeutic programs designed to improve acceptance and commitment among people with personal lived experience), particularly for experiences of mental ill-health outside of depression. A stronger evidence base for the effectiveness of these approaches is important because online programs have the potential to reach a wider audience
- specific interventions to reduce self-stigma experienced by the Lived Experience workforce
- specific interventions to reduce self-stigma experienced by support people.

Priority actions to reduce self-stigma

Priority actions to reduce self-stigma are listed in the table below. Addressing self-stigma at a population level is primarily dependent on actions to address public stigma and structural stigma and discrimination, which are presented across *Priority 2: Reduce structural stigma and discrimination* and *Priority 3: Reduce public stigma*. The actions in the following table are intended as a complement to all initiatives recommended throughout the (Draft) Strategy.

Ref	Action	Timeframe	Who's responsible	Expected changes
4a	Conduct research into prevalence and experience of self-stigma among: • people with personal lived experience • Lived Experience workforce • families and support people • general population	Short term	National Mental Health Commission	Increased availability of quantitative prevalence data and qualitative experience data for people with personal lived experience, Lived Experience workforce, families and support people and the general population
4b	Establish national and/or regional communities of practice for Lived Experience workers	Short term	Lived Experience peak/ advocacy organisations	Increased access to formal and informal supports for the Lived Experience workforce Decrease in prevalence of self-stigma among Lived Experience workforce
4c	Fund the development and evaluation of programs that are designed to build stigma-resistance, resilience and self-compassion. Programs must be culturally responsive (co-developed with Aboriginal and Torres Strait Islander people with lived experience)	Medium term	National Mental Health Commission	Increased availability of evaluation data in an Australian context for targeted self-stigma-reduction programs
4d	Drawing on additional evidence generated from the actions listed above, develop guidelines defining best practice for self-stigma reduction, co-designed with people with personal lived experience and incorporating a human rights-based approach	Long term	National Mental Health Commission	Increased understanding of evidence-based interventions which address self-stigma

Evaluating the Strategy

Building a strong and consistent evidence base around stigma and discrimination requires a robust approach to evaluation and monitoring across all areas of stigma and discrimination presented in this (Draft) Strategy. As there are many different definitions of both stigma and discrimination, and mental ill-health, and many tools and frameworks available to measure stigma and discrimination in the literature, a comprehensive and rigorous approach is required.[314] The Commission commits to continuing to gather evidence about what works and to evaluating the impact of the Strategy.

Key gaps exist in the evidence base around stigma and discrimination in Australia, particularly regarding intersecting forms of stigma and discrimination among people with personal lived experience. There is limited population level knowledge related to public stereotyping, prejudice and social exclusion. For example, there is a lack of understanding of these experiences for those with personal lived experience beyond specific clinical diagnoses of depression or schizophrenia.[315, 316] Comprehensive evaluation increases the evidence base and supports a baseline understanding of experiences of stigma and discrimination. Evaluation also facilitates the measurement and continuous improvement of interventions to address it.

Monitoring and evaluation of the implementation of stigma-reduction initiatives, including any that are implemented in response to this (Draft) Strategy, should employ a mixed-methods approach, using an implementation science framework (e.g. RE-AIM), validated data collection tools and qualitative methodologies. The evaluation approach should collect data about population-level prevalence and experiences, in addition to that relating to priority populations. While the evaluation outcomes of specific interventions may differ based on the purpose of the intervention, they should broadly seek to understand:

- attitudes toward people with personal lived experience among target populations
- qualitative and quantitative data about the prevalence and experience of mental health-related stigma and discrimination at a population level and among priority populations.

Appendix A: Governance group members

Steering Committee

- Professor the Hon Kevin Bell AM KC (from September 2021) **(Co-Chair)**
- Tanya Blazewicz
- Dr Tessa Boyd-Caine
- John Canning
- Dr Sarah Chalmers
- Kelly Clark
- Professor Allan Fels AO
- Tim Heffernan **(Co-Chair)**
- Professor Jayashri Kulkarni AM (to September 2021) **(Co-Chair)**
- Maria Katsonis
- Mark Orr AM
- Lisa Paul AO PSM (to February 2022)
- Dave Peters
- Professor Nicholas Procter
- Navin (Sam) Regi

Self-Stigma Technical Advisory Group

- Megan Ansell
- Nic Brown
- Associate Professor Cath Chapman
- Tony Clarkson **(Co-Chair)**
- Anu Dhingra
- Dr Amy Finlay-Jones
- Professor Jennie Hudson
- Anna-Louise Kimpton
- Tandiwe (Tandi) Kuwana

- Jack Nagle
- Emeritus Professor Susan Paxton
- Dr Imogen Rehm
- Professor Debra Rickwood
- Dr Zac Seidler
- Lucy Thomas OAM **(Co-Chair)**

Public Stigma Technical Advisory Group

- Margaret Doherty
- Samuel Hockey
- Dr Fincina Hopgood
- Melissa Hopkins
- Sandy Jeffs OAM
- Neall Kriete
- Jess Mitchell **(Co-Chair)**
- Dr Amy Morgan
- Naseema Mustapha
- Dr Bridi O’Dea (to March 2022)
- Dr Elizabeth Paton
- Sophie Plumridge (to X 2022)
- Associate Professor Jo Robinson **(Co-Chair)**
- Adjunct Associate Professor Sophie Scott
- Andrew Thorp
- Scott Wilson

Reducing Structural Stigma and Discrimination Technical Advisory Group

- Margaret Doherty
- Jess Mitchell **(Co-Chair)**
- Samuel Hockey

- Dr Fincina Hopgood
- Melissa Hopkins
- Sandy Jeffs OAM
- Neall Kriete
- Dr Amy Morgan
- Naseema Mustapha
- Dr Bridi O’Dea (to March 2022)
- Dr Elizabeth Paton
- Sophie Plumridge (to X 2022)
- Associate Professor Jo Robinson **(Co-Chair)**
- Adjunct Associate Professor Sophie Scott
- Andrew Thorp
- Scott Wilson

Measurement Technical Advisory Group

- Sasha Banjavic-Booker
- Professor Phil Batterham **(Co-Chair)**
- Jo Farmer **(Co-Chair)**
- Dr Chris Groot
- Professor Carol Harvey
- Dr Mark Loughhead
- Dr Ashley McAllister
- Professor Vera Morgan
- Ali Noura
- Professor Nicola Reavley

Appendix B: Glossary

Key terms relating to stigma and discrimination

Terminology	Definition
Stigma	The disapproval of, or discrimination against, an individual or group based on characteristics that serve to distinguish them from other members of a society. Stigma results from complex social, political and psychological processes and can include negatively stereotyped characteristics, attitudes and responses that are community socialised and/or structural which harm a person's day-to-day health and wellbeing by excluding, devaluing or shaming them.[317]
Self-stigma	The process in which a person with personal lived experience becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to the self. The person comes to believe these negative messages or stereotypes about mental ill-health and applies these to themself.[318]
Public stigma	Negative thoughts, feelings and behaviours held or expressed by individuals towards people who experience mental ill-health.[319] As a result of public stigma, people living with mental ill-health are negatively categorised, othered, and lose status and power in society. This leads to widespread discrimination against people with mental ill-health, which limits a range of life opportunities.[320230]
Structural stigma	When laws, policies, practices and organisational structures enable unfair treatment of people who experience mental ill-health.[321] This includes where it is much harder for people who experience mental ill-health to access vital services and to participate in society.
Discrimination	Discrimination occurs when a person, or a group of people, is treated less favourably than another person or group because of their background or certain personal characteristics. This is known as 'direct discrimination'. It is also discrimination when an unreasonable rule or policy applies to everyone but has the effect of disadvantaging some people because of a personal characteristic they share. This is known as 'indirect discrimination'. Discrimination can be against the law if it is based on a protected attribute, including disability. Discrimination on such grounds is against the law in a number of areas of public life, including employment, education and accessing premises.
Perceived stigma	A person's awareness or perception that the public holds prejudice, negative views or engages in discriminatory behaviour towards people who experience mental ill-health.
Anticipated stigma	A fear that prejudice, discrimination and stereotyping will be directed at the self from others in the future. The experience of

	perceived stigma is central to anticipated stigma, and often results in withdrawal from opportunities.
Associated stigma	Stigma by association involves disapproval towards those who associate with people whose experiences are stigmatised. It can affect family, friends, carers, support people and health workers.
Mental ill-health	Mental ill-health is an umbrella term to describe experiences of psychological distress or mental illness, including experiences of trauma, suicidality, and alcohol and other drug issues. In defining mental ill-health in this way, it is acknowledged that some individuals may have experiences which meet this definition, but do not describe them in this way (see Language matters).
Personal lived experience	People with a lived or living experience of psychological distress, mental ill-health, trauma, suicidality, suicide attempt and alcohol and other drug issues. For Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds, personal lived experience also recognises social and emotional wellbeing encompassing the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family and community.
Families and support people	A current or previous experience of being an unpaid carer or support person for someone experiencing mental ill-health, trauma, suicidality or distress, including families, friends and anyone whose primary relationship with the person concerned is a personal, supporting and caring one.

Other key terms

Terminology	Definition
Addiction	A chronic health condition that occurs when someone finds it difficult to stop consuming a drug or engaging in an activity or pattern of behaviour, even if it is causing physical or psychological harm, or adversely affecting their life. This is sometimes referred to as dependence.
Attitudes	A relatively enduring and general evaluation of an object, person, group, issue, or concept on a dimension ranging from negative to positive.
Behaviours	Activities in response to external events, situations or internal thoughts and feelings, including objectively observable activities.
Carer or support person	A person who plays a vital role in supporting a person experiencing mental ill-health. They provide emotional or practical support. They may be a parent of someone with mental ill-health, or an adult caring for a partner, parent, sibling, other family, kinship group member or friend, or a child who looks after a family member with mental ill-health, such as a parent or sibling.

Contact-based approach	Interventions involving members of the public observing or interacting with an individual who lives with mental ill-health.[230] Examples of these include music, arts, and community events such as The Big Anxiety, Schizy Inc events, MAD Poetry, and Listening to Voices performance.
Co-occurring conditions	The experience of multiple health or mental health problems, including the experience of mental ill-health and alcohol or other drug problems or other forms of dependence. These may be experienced at the same time or over the course of a person's lifetime.
Cultural norms	A societal rule, value, or standard that delineates an accepted and appropriate behaviour within a culture.
Cultural safety	Overcoming the power imbalances of places, people and policies that occur between the majority non-Indigenous position and the minority Aboriginal and Torres Strait Islander person so that there is no assault, challenge or denial of the Aboriginal and Torres Strait Islander person's identity, of who they are and what they need. Cultural safety is met through actions from the majority position which recognise, respect, and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people. Only the Aboriginal and Torres Strait Islander person who is recipient of a service or interaction can determine whether it is culturally safe.
Diagnostic overshadowing	Misattribution of a person's physical health symptoms to their mental illness, resulting in inadequate diagnosis and treatment.
Dignity	A person's inherent and equal worth.
Disability	The result of the interaction between a person's illness or condition and social, attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.
Economic dignity	When people are treated with respect, have meaningful control over the choices they make in life, are able to serve in a role (such as in paid work) valued by them and society, and where their essential needs are met.
Equity	The idea of being fair and impartial as an individual engages with an organisation or system.
Human rights	Fundamental rights and freedoms that all people are entitled to enjoy and exercise.
Intergenerational trauma	This is the trauma experienced by Aboriginal and Torres Strait Islander people as a consequence of colonisation and its continuing effects, including through historical and current experiences of child removal, incarceration, disadvantage and racism. Intergenerational trauma is associated with high levels of psychological distress and suicide.
Intersectionality	An analytical framework for understanding how aspects such as race, gender, sexuality, ability, culture and class intersect to

	create overlapping and interdependent systems of discrimination and disadvantage for individuals and communities.
LGBTIQA+	An acronym that is a way of referring collectively to people who are lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, or questioning, asexual and those who have other diverse experiences regarding sexual orientation, gender and sex characteristics.
Lived Experience workforce	Consistent with the *National Lived Experience (Peer) Workforce Development Guidelines*, the 'Lived Experience workforce' is a collective term that includes both the personal lived experience (consumer) and family/carer workforces. However it is recognised that these are separate workforces and the role types have distinct ways of working, informed by different types of understanding/experience and with differences in the way values are applied. When referring to roles or the workforce the term 'Lived Experience' is capitalised to distinguish the professional from the personal, i.e. working in a Lived Experience role as opposed to 'having a lived experience'. The Lived Experience workforce includes but is not limited to: Consumer Consultants; Carer Consultants; Peer support workers; family/carer peer support workers; specialist peer workers; and various designated Lived Experience roles in executive governance; paid board and committee representation; education; training; research; consultancy; policy design; and systemic advocacy across various service settings. Designated Lived Experience roles include all positions that require lived experience as key criteria, regardless of position type or setting. Key to qualification for Lived Experience roles, is that the experiences were so significant they caused the individual to reassess and often change their lives, their future plans, and their view of themselves.
Mental health literacy	Knowledge and beliefs about mental disorders which aid their recognition, management or prevention.
Person-centred	A model of treatment, care and support that involves partnership between a person, their families and support people and professionals in health and other types of services, where care is planned and performed in a way that recognises and maximises the person's agency, autonomy and decision-making capacity.
Prejudice	The feelings or other reactions that people have toward a group or member of a group. Most often, these feelings are negative, although they do not necessarily need to be. The most common forms of prejudice toward people with mental ill-health are fear, pity, and anger.

Privilege	Refers to certain social advantages, benefits, or degrees of prestige and respect that an individual has by virtue of belonging to certain social identity groups.
Psychological distress	State of emotional suffering associated with stressors and demands that are difficult to cope with in daily life.
Racism	Racism is prejudice, discrimination or hatred directed at someone because of their colour, ethnicity or national origin. Racism can be internalised or experienced at an interpersonal, institutional or systemic level.
Recovery	While there is no single description or definition of recovery because recovery is different for everyone, recovery often refers to being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. Central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.
Social and emotional wellbeing	Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental and physical health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.
Stereotype	A generalised belief about a particular category of people. It is an expectation that people might have about every person of a particular group.
Trauma	The term “trauma” refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual’s physical, social, emotional, or spiritual wellbeing. Coercive and compulsory treatment and practices can cause trauma.
Trauma informed care and practice	An organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological, social and cultural effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for people with lived experience, their families and support people, and service providers.
Work health and safety	The management of risks to the physical and psychological health, safety and welfare of everyone in a workplace, by minimising risks, ensuring fair and effective representation and cooperation, promoting information education and training and providing effective compliance and enforcement measures.

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