The seeds of mental illness were planted when I first started school. I couldn’t talk properly and I was overweight. I felt pretty inadequate, was very shy, and had poor self-esteem. So kids laughed at me and teased me.

In my 20s I was involved in the local football club. I was out late drinking then early the next morning I would get up to do the milking on the farm. Something was bound to give and it did. I was admitted to a psychiatric institution.

Dad was a great support when I was unwell. He called my friends and told them what had happened. These conversations removed a lot of the stigma of mental illness. They were on board with being my support network straight away.

When I returned home from the psychiatric facility I had lots of side-effects from the medication which prevented me running the farm. Dad came out of retirement to help out. I would milk with Dad’s help in the early mornings and evenings and then sleep during the day. Even though I resented the early morning milking at the time, it was a good thing to have a routine. Today, I have been lucky enough to keep the family farm.

My wife thought it was a good idea to tell my story. Now I talk about mental illness and stigma with Year 9 students. One of the key messages I tell the kids is ‘say positive things, don’t tell them what they have done wrong’. I want to let people know that mental illness is not the end of the world.

Life is like a game of football. Sometimes life is going pretty good and you are winning by 10 points. But sometimes you lose by 5 or 6 points and you feel pretty helpless and you wonder what went wrong. You can analyse the game, work out what happened and not make the same mistakes.

This is like my life. Although I have had some bad things happen, in the long run my life has been a blessing.

And so it is with your life.

Watch Jack’s video at www.mentalhealthcommission.gov.au
Introduction

The way that we as a community often shun people who live with a mental health difficulty erodes their quality of life. Everyone has the right to be treated without discrimination, but for people experiencing mental illness, being ignored, talked down to, or treated ‘differently’ is a lived reality in everyday interactions.

Communities that are diverse are stronger when people have an understanding of each other. Strong communities contribute to our wellbeing. These benefits are undermined when we feel excluded from participating and when there is little acceptance of diversity. All too often people with mental health difficulties experience this, and frequently raise stigmatising attitudes as their greatest concern.

This experience of stigma and discrimination also affects their families and support people. This chapter will focus upon how our understanding of mental health issues affects how we treat or discriminate against people living with a mental health difficulty and their family or support people. It will look at how well our communities understand mental health, and what the consequences of poor understanding are for us as a community and for the lived experiences of people with a mental health difficulty to lead a contributing life.

Under the Australian Disability Discrimination Act 1992, discrimination is defined as the treatment of (or proposal to treat) another person less favourably on the basis of their disability when compared to other people. This can be intended or unintended, and this law applies to how ‘people with a psychiatric disability’ are treated as well as their families and support people.

We will look closely at discrimination at the broader community and institutional scale, as well as the micro-scale of individual interactions.

What we know

In just about every sphere of life – making friends, living next door to or working closely with someone, falling in love – we know entrenched discriminatory attitudes exist. Too many of us still hold discriminatory and prejudiced views about mental illness and towards people who live with schizophrenia.

The 2011 National Survey of Mental Health Literacy and Stigma found that:

- just under half (45.1 per cent) of people surveyed indicated they would not want a person with schizophrenia marrying into their family and around a quarter (28.2 per cent) would not want someone with depression marrying into their family;
- between 32.6 per cent and 48.6 per cent of people would avoid someone with a mental health difficulty – from avoiding people with Post Traumatic Stress Disorder (PTSD) to those with chronic schizophrenia;
- 37 per cent of people would not employ a person with chronic schizophrenia and 23.4 per cent would not employ someone with depression.

It is unacceptable that people who live with the most disabling mental illness also face the most discrimination and misunderstanding, as Figure 3 shows.

Figure 3: Attitudes to employing someone with varying mental health disorders

<table>
<thead>
<tr>
<th>Mental Health Disorder</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0</td>
</tr>
<tr>
<td>Depression with suicidal thoughts</td>
<td>20</td>
</tr>
<tr>
<td>Early schizophrenia</td>
<td>0</td>
</tr>
<tr>
<td>Chronic schizophrenia</td>
<td>40</td>
</tr>
<tr>
<td>Social phobia</td>
<td>0</td>
</tr>
<tr>
<td>PTSD</td>
<td>0</td>
</tr>
</tbody>
</table>

Maintaining connections with family, friends, community and culture

Attitudes to socialising have not shifted over the last eight years, as shown in Figure 4.

We know that such discrimination can play out in the small and daily interactions between people. These micro-inequities, where minor instances of discrimination or inequality are experienced repeatedly, build up to compound a person’s experience of discrimination.77 These experiences can even be felt coming from those who are supposed to be providing help.79

This surely contributes to the fact that 65 per cent of the estimated 3.2 million Australians who have experienced a mental health problem in the past 12 months have not sought help.49

In one survey, 61.4 per cent of carers reported feeling that the health professionals treating the person they supported did not really understand what it meant to have a mental illness, while 31.3 per cent had seen the person they cared for shunned by health professionals when it was revealed they had a mental illness.79

National and international research shows that discriminatory behaviours compound self-stigma, discouraging people from participating fully in treatment, with negative impacts upon their recovery and health.78 They also withdraw from daily activities.75, 76

The early findings of the Commission’s own pilot online survey found that 23.3 per cent of respondents said that social discrimination ‘got in the way’ of them feeling connected to family, friends, culture or community.58

We also know that discrimination associated with mental illness extends to families and can affect their own behaviour.59 Misunderstandings of a family’s role or responsibility can lead to negative attitudes from health professionals which make family members feel discounted or ignored,80 and can inform how people outside the family react.81

In one survey of support people: 10.6 per cent of support people reported being treated often or very often as “less competent” by others when they learned they were a mental health carer.30 per cent avoided telling people outside their immediate circles that they were a mental health carer. About 60 per cent of respondents had experienced negative, hurtful and offensive attitudes from the public.78

Discrimination and bullying – for example at work, or because of sexual orientation or race – contribute to poor mental and physical health and suicidal behaviour, which can carry over into adulthood.84 In Queensland, of 63 youth suicides in 2011/12, at least three were directly attributable to bullying.85

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Figure 4: Reported desire to keep a social distance from people with selected mental illnesses

![Figure 4: Reported desire to keep a social distance from people with selected mental illnesses](chart)

Source: 2013 National Mental Health Report

We know that the Australian media continues to play a powerful and influential role in shaping and changing attitudes through informed reporting.86-89

About 60 per cent of respondents had experienced negative, hurtful and offensive attitudes from the public.78

Discrimination and bullying – for example at work, or because of sexual orientation or race – contribute to poor mental health.59 We know that young people who are bullied are at-risk of higher rates of poor mental and physical health and suicidal behaviour, which can carry over into adulthood.84 In Queensland, of 63 youth suicides in 2011/12, at least three were directly attributable to bullying.85

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Experience of discrimination among Aboriginal and Torres Strait Islander peoples

Experience of discrimination is culturally variable

Social and emotional wellbeing and the impacts of racism

Aboriginal and Torres Strait Islander peoples describe their mental health as having a foundation of ‘social and emotional wellbeing’ originating in a network of relationships including those between the individual and their community traditional lands, family and kin, ancestors and the spiritual dimension of existence. Life is understood in holistic terms: with the health of individuals and communities evident not simply by the absence of disease but linked to their ‘control over their physical environment, of dignity, of community self-esteem, and of justice.’ Respect for Aboriginal and Torres Strait Islander rights is fundamental to social and emotional wellbeing: racism and discrimination are associated with negative physical and mental health impacts.

The approach of ‘social and emotional wellbeing’ provides a less stigmatising description of mental health than the western culture’s views, based as they are on formal psychiatric/medical definitions and concepts. For Aboriginal and Torres Strait Islander peoples living with a mental health condition, a ‘matrix of discrimination’ (reflecting compounding and cumulative experiences of racial discrimination and stigmatising attitudes towards their mental health condition) can be particularly challenging. In practice, it may not be possible for such a person to identify precisely why they have been discriminated against, in any given situation. Likewise, it will not be necessarily possible to separate out the existence of a mental health condition from the experience of racial discrimination. Almost without exception, international studies find that racism and racial discrimination are associated with poorer mental health status – findings echoed in the eight studies on the impact of racism on Aboriginal and Torres Strait Islander peoples that have occurred to date.

When discussing the stigma faced by Aboriginal and Torres Strait Islander peoples with mental health conditions, it is important that forms of discrimination are not viewed in isolation and that any effort to address stigma on the grounds of mental health acknowledges and incorporates Aboriginal and Torres Strait Islander people’s lived experience of racial discrimination.

Experience of discrimination among Culturally and Linguistically Diverse (CALD) communities

Cultural attitudes and understanding

The diversity of peoples’ beliefs, understanding and response to mental illness is shaped by their cultural heritage and experience. While a refugee’s mental health may be affected by their experience of trauma in reaching Australia, their understanding of ‘mental health’ and that of their family and community will also reflect their heritage. There is a broad diversity of understanding regarding the causes, expression and outlook for different illnesses. The Western model of mental ill-health is often felt to be inappropriate by many people and does not speak to their experience, which may be influenced by a combination of social, religious, biological, psychological and cultural explanations.

There is some evidence that there can be high levels of stigmatising attitudes in some CALD communities, as there can be in all communities. Some understandings of mental illness do link it to shame, humiliation and ‘loss of face’. People from these diverse communities may have a different experience of mental illness, be less likely to disclose symptoms, more likely to express distress in the form of physical symptoms, and less likely to seek treatment which they may feel is inappropriate.

This is compounded by limited availability of inclusive services which can provide culturally sensitive interventions, services and interpreters. Young refugees, adolescents in particular, are more likely to seek help from friends than from professionals because of stigma associated with mental health problems. A study of West African women living in Western Australia showed their feelings of shame or fear of being judged by others hindered their willingness to access health care services.
Creating cultural understanding

What it means for Antonia, New South Wales

As a Greek mother caring for two adult children, sharing my story as I tried to reach out for assistance and support has led to an ongoing process of healing and enlightenment, not just for me, but for other members of my community.

It’s been 26 years now since my daughter’s mental illness was first diagnosed. It was like hell and it didn’t get any better when my son’s mental illness was diagnosed a few years later. All my time and energy was taken up for them — organising help, negotiating with treatment services, getting them support … or trying to. Even when I succeeded getting some help for them, the impact of the stigma and the chaotic lifestyle left our family struggling to survive. It never occurred to us that we deserved some help too.

I became involved with a Greek Carers’ Support Group. I was frightened and anxious because of how I had been treated by other members of my community in the past. People who I went to for support began to ask me to share my experiences more widely and I began to have requests from various groups to talk about my experiences.

The more my stories were heard the more opportunities there were. I am currently leading five Greek Carers Support Groups and I was awarded the NSW Carer of the Year Award in 2011.

Reaching out to others not only meets my needs but empowers you to help others to meet theirs. The more opportunities we take to share those painful episodes of our lives, the more we are empowered, and the more other people will feel encouraged to add their chapter to the story and gain their portion of healing.

Watch Antonia’s video at www.mentalhealthcommission.gov.au
What the evidence shows is good practice

The evidence we have is inconsistent in quality and therefore in the reliability of conclusions drawn.

However, national and international studies suggest that longer term anti-stigma and discrimination initiatives have more success in reducing the experience of discrimination by people living with a mental health difficulty than short-term initiatives.203

The main focus of investment in Australia since 1992 has been on broad mental health education and community understanding programs. Such programs may be successful for many people and have increased overall mental health literacy, but more targeted programs are needed for people who come into frequent contact with people with mental health problems, such as health professionals, police and workers in the justice system.

This is where Mental Health First Aid (MHFA), a training course based on person-to-person mental health education, has been effective in improving mental health literacy and reducing stigma all over the world. MHFA was developed in Australia in 2001204 and teaches people (18 years and over) how to provide initial support to adults who are developing a mental illness or experiencing a mental health crisis. There is also a course for adults working or living with adolescents.

With its evidence of effectiveness supported by high quality evaluations and global uptake, this is an example of international best practice. For example, it has been found to be effective in workplaces and with CALD communities.211

Only a relatively small number of initiatives have been evaluated. Evaluations of effective programs for Aboriginal and Torres Strait Islander peoples, as well as people from CALD communities, is complicated by the differences in understanding of mental illness between cultures and in the social acceptability of reporting symptoms.204

And again, there may be good practice models in operation, but these have not been evaluated.

Policies for reducing bullying have been developed for schools and workplaces. Identifying where good practice lies may be in bringing together key elements – having involved adults at school, open discussion with established boundaries on acceptable behaviours, having leadership, clear bullying policies and expectations for behaviour that are implemented.212

“Public awareness of mental health needs to increase. At the moment I feel like it is a taboo subject in the community and it needs to be able to be talked about more.”

“We work with people negotiating their gender, sexuality and/or intersex status and have developed education and training programs aimed to provide clear messages about stigma and discrimination, and the impact these have on a person’s sense of wellbeing.”

Susan Ditter, Working It Out Tasmania
What we don’t know

Where we need more evidence, and to shine a light

Mental health promotion and awareness programs have been rolled out across our country. Spending by states and territories on these programs alone came to $16.4 million in 2010-2011, with grants to non-government organisations totalling an extra $19.65 million.

Despite this, the Commission is concerned that we have insufficient evidence to ensure that money is being spent in the most effective way. Some examples of gaps in our knowledge are as follows.

- Studies of whole-of-community, anti-stigma interventions in Australia are of insufficient quality and number to allow conclusions about effectiveness to be drawn about what works.
- There is also inconclusive evidence about school-based and tertiary education-based campaigns in improving mental health literacy of students.

We need to have a better understanding of why improvements in overall community understanding of mental health do not translate into equal levels of improvement in reducing discrimination and stigma.

We need to know why stigmatising attitudes and prejudice persist. To support this, we need to address our gaps in knowledge about why certain groups in our community hold more discriminatory views and attitudes, and what types of approaches are most effective in changing this.

“Studies of whole-of-community...”

We do not fully understand the social and cultural factors that underlie stigma, or the ways in which it can be reduced and prevented. Further investigation is needed to identify how stigmatising attitudes arise and why they persist, and to generate evidence about what works to reverse them. There are many people who experience discrimination even without having mental illness. For those people—including refugees, people affected by drugs, different ethnic groups, people identifying as lesbian, gay, bisexual, transgender or intersex (LGBTI), homeless people, cognitively impaired people, and physically disabled people—developing a mental illness can exacerbate or even be a result of the experience of discrimination.

“Studies of whole-of-community, anti-stigma interventions in Australia are of insufficient quality and number to allow conclusions about effectiveness to be drawn about what works.”

“A person’s identity and sense of belonging are critical to building resilience and being a participating member of the community.”

Susan Ditter, Working It Out Tasmania

“In any community you get out of it what you put into it. Being in the community itself, the word community doesn’t exist if you don’t work with it and get involved with people.”

11
Creating healthy workplaces

What it means for Margo, Victoria

Workplaces are a logical environment for building a strong sense of community connectedness and belonging. They have a crucial role in at least protecting, and possibly promoting dignity and respect, security, integrity and autonomy of the person. They can serve the need to feel a part of a community in which there is respect for due process and fair procedures.

Employers who invest in understanding mental health issues and how mental illness or poor mental health may affect their staff are typically rewarded with a higher trust environment, improved morale and a more loyal and productive workforce. There are many simple and inexpensive ways to do this—team lunches, creating opportunities for collaboration across teams, workplace mentor and leadership programs and social club activities.

Another highly effective way to improve understanding is through specialist training about mental health. As well as basic management training for frontline managers and supervisors, training on mental health is an excellent way to increase the confidence and capacity of managers. It assists them to identify someone who may be at risk and facilitate access to the right treatment, or to support someone experiencing mental illness in their recovery and return to work.

SuperFriend has seen this in the Industry Superannuation sector, where we facilitate tailored mental health and wellbeing training to superannuation and insurance staff. In an industry that can deal with members at stressful times, these sessions provide opportunities to build staff capability and improve member outcomes, decrease stigma about mental illness in the work and broader community, and lastly, benefit the staff teams with a greater shared understanding and an increase in team morale.

Employers are coming to understand the economic sense, as well as the social benefits of investing in their people’s mental health and wellbeing. After all, good work is good for peoples’ mental health, as it provides us with social interaction, a sense of purpose and sense of community contribution.

Watch Margo’s video at www.mentalhealthcommission.gov.au
Spotlight issue

Attitudes underlying policies and programs

Discrimination towards people living with a mental illness can be overt or subtle.\textsuperscript{115}

Of most concern to the Commission is any discriminatory process or behaviour, which limits the choices or opportunities of people living with a mental health difficulty.

Discrimination operates at both the institutional and interpersonal level.

**Discrimination at the institutional level: ‘structural discrimination’**

The Commission is interested in two aspects of institutional discrimination.

The first is discrimination at work towards employees. For many of us, our workplace – where we spend many hours – provides an environment for meaningful occupation, social networks and personal reward. Discrimination at work can undermine both the benefits of work and harm our mental health. It can lead to loss of income, housing and financial independence.

Workplaces that tolerate discriminatory attitudes and behaviour, as well as bullying, are cultures that are no longer publicly tolerated. We see large employers, public and private, openly redressing the problems of past institutional practices. Forty-two employers recently responded to the Mentally Healthy Workplace Alliance’s call for good practice, giving real examples of what has worked and what hasn’t.\textsuperscript{2}

Our second concern is where policies or procedures explicitly, or more often implicitly, discriminate against people who experience a mental health difficulty. This may not be overt or intentional, but it still falls within the definition of discrimination under the Australian Disability Discrimination Act 1992.

It may reflect the lack of awareness of how the policy may unintentionally impact upon someone with a mental illness or not take into account the psychosocial disability that they may experience.

This may be most clearly seen in getting and keeping a job. We have heard from the Mental Health Legal Centre of Victoria that having a forensic psychiatric history directly affects job prospects\textsuperscript{116} and from the Australian Human Rights Commission that where psychosocial difficulties affect performance it can lead to dismissal.\textsuperscript{117}

Barriers can also be posed by routine practices. For example, barriers to getting government housing start with the application process itself. One Australian study of 372 people with a mental illness who had applied for public housing found that 90 per cent reported difficulties with the complexity of the application process.\textsuperscript{118, 119}

Again, the Disability Discrimination Act would require the housing provider to accommodate the person’s needs arising from their disability.

**Discrimination at the micro discrimination, interpersonal level:**

Discriminatory attitudes in the workplace, for example, can affect recruitment decisions and therefore equal opportunity for meaningful work.

A literature review for the Mentally Healthy Workplace Alliance showed a tendency for employers and society in general to see people living with mental health difficulties as being incapable of engaging in employment.\textsuperscript{120}

To help people living with a mental health difficulty who, as a group, are already under-employed and unemployed at higher rates than the general population, we need strong workplace leadership, positive and open cultures and polices that are implemented.

This will help to ensure that employers:

- do not have lower expectations of people with health problems, but put measures in place to ensure that they have the same opportunities as others; and
- acknowledge that living with a mental illness does not necessarily affect a person’s capabilities or capacity to work or make decisions. While illness may affect a person when they are unwell, under Australian law employers are required to be flexible in accommodating their health needs as for any other illness.
Maintaining connections with family, friends, community and culture

We know that improvements in community understanding have not been paralleled by a reduction in discriminatory behaviour and attitudes. The Commission looks to ways to push ahead in improving those areas most impervious to change.

We therefore call for a sustained national strategy for reducing discrimination. This needs to be multi-faceted and deployed at the community level. It needs to feature evaluation from day one. It should target groups we know remain resistant to improvement, who are in frequent contact with people with mental health problems and their supporters, and where we can make the biggest impact on attitudes and behaviour.

The benefits that can be gained from a sustained reduction in discrimination are measurable – and we look to national indicators to do this. There is a potential return on investment from this approach that needs to be universally acknowledged. The benefits will accrue on the personal level, at the family and community level, and across our nation in workplaces and schools.

**The Commission looks for improvement in specific areas:**

As stigma from health professionals is an area of significant concern to people living with a mental health difficulty and their support people, we need to tackle this as a priority.

There is also a clear need for approaches to address mental health literacy and stigma in Aboriginal and Torres Strait Islander communities. These must be culturally appropriate and developed and driven by Aboriginal and Torres Strait Islander peoples, to reflect their culture, history and social approaches to mental health and wellbeing.

We must also not forget the need for improved mental health understanding across CALD communities, and for cultural diversity to be reflected in practice.

Research shows that discriminatory attitudes vary with particular mental health conditions. Further work should address mental health literacy and stigma reduction, particularly in relation to schizophrenia. Some of the most discriminatory attitudes are directed at people living with this illness, yet it is one of the least prevalent mental health conditions. Similarly, we must continue to challenge some persisting misconceptions about the more common mental illnesses, such as anxiety disorders and depression.

In all efforts to reduce discrimination, we must incorporate the voices of people with experience of mental health problems and their families and support people. Their expert feedback can help to create more responsive and higher quality services and can be especially powerful to drive attitude change.

**Where the Commission is looking for continuous improvement**

In a human service organisation, the lived experience of people with mental illness and their families and support people is directly affected by the skills, attitudes and behaviour of staff. Staff who have clear objectives and well-structured appraisals are more likely to report they are engaged in the work of their organisations than those who do not. Engaged staff are those who are well led, with the leaders of frontline teams having a particularly important role in creating a climate for changing attitudes.

We will not make a difference to peoples’ lives unless we are all prepared to stand up against discrimination wherever we may witness it.

The Commission believes it is time to positively discriminate in favour of people living with a mental health difficulty. We believe that just improving understanding of mental health issues in the community is insufficient. It is only by starting with our everyday interactions, within our families, schools and workplaces, that we can foster behaviours which are inclusive. If people feel more included, they are more likely to seek help when it is most effective.