CoMHWA

Consumers of Mental Health WA (Inc)

Feedback to the

National Mental Health Commission

Consultation: National Stigma and Discrimination Reduction Strategy

1/02/2023

Consumers of Mental Health WA

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Narda Stigma Birds – Damien Watt (Koori, Noongah), CoMHWA member

“If we all removed the stigma from our eyes, we could all be as beautiful as those birds. The dots signify different people and lifestyles; the colours change shade throughout the dot work to signify that we are all different yet the same.”

1. Preliminaries

About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy group independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

Language

CoMHWA uses the term mental health consumer throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

About the Consultation: National Mental Health Commission "Stigma and Discrimination Reduction Strategy"

Reproduced from National Consultation material:

"The National Mental Health Commission is developing the National Stigma and Discrimination Reduction Strategy. The Commission has drawn on existing research and consulted with people with direct personal lived experience, families, friends, unpaid carers and support people, researchers and industry leaders.

The NMHC have now released a Draft Strategy, and are inviting feedback from a broad range of stakeholders, including:

- people with lived experience of mental ill-health, trauma, distress or suicidality
- families, carers and support people
- people working in the services and settings of focus for the Strategy such as health professionals, social services, business owners, educators, and legal and financial services.

The Strategy's focus and objectives include:

- Reduce self-stigma amongst those who experience mental ill-health and those who support them.
- Reduce public stigma by changing attitudes and behaviours in the general community and amongst identified target audiences.
- Take steps towards eliminating structural stigma and discrimination towards those affected by mental ill-health in identified settings.

The Strategy will initially concentrate on stigma and discrimination reduction in the following settings:

- Mental Health System
- Health System
- Financial Services and Insurance
- Legal Systems
- Education and Training
- Employment
- Social Services, Disability, Income Support and Housing

The Strategy is being developed in partnership with people with lived experience and people who have been directly affected by stigma, along with people with other forms of expertise across the health sector and broader community."

Close Date: 1 February 2023
Submissions to:
https://haveyoursay.mentalhealthcommission.gov.au/provide-feedback-draft-national-stigma-and-discrimination-reduction-strategy

2. Introduction

CoMHWA welcomes the opportunity to make a submission as part of consultation in the development of a national strategy to reduce stigma and discrimination being undertaken by the National Mental Health Commission. We believe that this strategy has an important part to play in improving the wellbeing of consumers of mental health.

We base our submission on:

- Ongoing consultation with consumers in Western Australia on joint priorities for an improved mental health system.
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).
- Discussion of Stigma and Discrimination issues with WA and interstate advocacy groups, representing mental health consumers, health consumers, CALD communities and young people.

We also held a focus group with our Consumer Advised Systemic Advisory meeting to specifically discuss the strategy. A number of key issues themed around the priorities (Foundations, Structural Stigma, Public Stigma and Stigma) were discussed and these will be highlighted in this submission. The key areas of discussion were employment; health; and education and training. Additional feedback regarding the document included that the strategy is still too vague without concrete or realistic goals. Further, that there is limited discussion on the needs of Aboriginal and Torres Strait Islander, ethnoculturally and linguistically diverse and LGBQTIA+ groups.

Discussion and Recommendations

Foundational Actions

The group did not raise any amendments for this section of the draft strategy.

Structural Stigma

Employment

Employment was the main issue of discussion during the focus group. Generally, the group argued that ensuring employment opportunities for people with lived experience is a crucial part of destigmatising the experience of mental health challenges to acknowledge that struggling with mental health should not be a barrier to fully participate in society. Members of the focus group discussed the experience of being given a diagnosis and informed on that basis that they will never work again. This is highly stigmatising and reinforces a narrative of mental health challenges as permanent, disabling and mutually exclusive of living meaningfully, which contradicts the basis of recovery approaches to mental health.

Key themes emerged from the discussion including a need to shift responsibility from individuals to the structures in which they are involved; the overemphasis on resumé gaps and how this may be dealt with respectfully; the stigmatising impact of psychometric testing in pre-employment processes; specific stigma that may manifest subtly in designated Lived Experience (Peer) roles or workforces; and how people with lived experience of mental health issues want to be perceived by employers and colleagues as a result of anti-stigma education and training in the workplace.

SHIFT RESPONSIBILITY FROM INDIVIDUAL TO STRUCTURAL

- Discrimination has always been upheld by shifting attention, blame (and therefore responsibility and accountability) from systemic issues to the individuals that are affected by them.
- There must be focus on changing the system and institution/s rather than placing responsibility on individuals to overcome so-called ‘inherent’ barriers for people with lived experience of mental health challenges.
- Reasonable adjustments or ‘micro-accommodations’ – the onus of supporting people with lived experience in the workplace should be placed back on the organisations to accommodate reasonable adjustments or small changes to employ a person so that they can still contribute.

- Better access to Workers Compensation for psychosocial harm, and making efforts to de-stigmatise the act of making such claims.

RESUMÉ GAPS—Education for employers about dealing with resume gaps.

- Asking invasive questions about resumé gaps that may or may not involve time away from the workforce to address mental health issues can derail conversation from job interview.
- Education is required for employers on how to address resumé gaps respectfully and professionally from employers' end. Any training or advice in this area should be informed by input from a diverse group of people with lived experience.
- Employers to acknowledge that time off work is not an 'easy' or 'relaxing' time, and people will have their own good-enough reason to have a resumé gap.

RESUMÉ GAPS—Education/support for people with lived experience

- Opportunities to get personal advice on how to communicate about resume gaps and lived experiences in both a job interview and ongoing as a member of the workforce.
- Personal support in explaining resume gaps while protecting dignity, safety and self-respect and without expectation to provide highly sensitive details that will make it difficult to remain professional. People with lived experience are often expected to disclose freely in ways that may be embarrassing, distressing and traumatic to justify gaps in resumes.

MANDATORY PRE-EMPLOYMENT PSYCHOMETRIC TESTING

- Mandatory psychometric testing before employment is ableist and discriminatory—no person should be disqualified or valued differently because of this. At the very least, if psychometric testing must be used, analysis of results should extend beyond identifying 'good/bad' 'suitable/not suitable' qualities, and instead should address how various personality types can be supported in and integrated into the workplace.
- It should be common knowledge that this is a stigmatising, discriminatory practice that does not support workplace wellbeing and promotes the idea that the workplace is only accessible to people with homogenous, prescriptive traits.

STIGMA IN DESIGNATED LIVED EXPERIENCE ROLES

- The distinction between ‘normal’ workers and peer workers can be unintentionally stigmatising without proper support and integration in a workplace. Making this distinction can often excuse or justify not having policies and procedures in place that acknowledge and accommodate lived experience in all levels, whether in designated Lived Experience (Peer) roles or not.
- Some policies instituted specifically for Lived Experience (Peer) workers may inadvertently disadvantage or ‘single out’ individuals in ways that measure or enforce hegemonic, dominant narratives of recovery (for example, implementing ‘wellness plans’ for Peer workers to complete and share with their managers, disclosing personal details and opening themselves up to scrutiny in ways that non-designated lived experience workers do not have to).
- This may function to erase the fact that people within the workforce already have ‘lived experience’ but don’t know how to use their experience or have their experiences legitimized as part of their role.
- Where lived experience is essential criteria for the role, but consequentially individuals must be medically assessed and/or disclose details that would not be expected in other professions.

HOW WE WANT TO BE VIEWED AS A RESULT OF ANTI-STIGMA EDUCATION TO EMPLOYERS/SERVICE WORKERS

- Education for employers/public service workers (e.g. employment agencies, especially those that market themselves as disability-friendly) about mental health issues should be:
    - Strengths-based.
    - Genuinely focused on how people with lived experience can function as valuable and reliable workers.
    - Aimed at giving people with lived experience of mental health challenges the respect they deserve rather than paternalistic or tokenistic inclusion.

RESULT: We want employers to see us in a positive light where diversity of experiences is acknowledged and valued, not merely ‘tolerated’.

Education and Training

- The use of storytelling as an education framework. People naturally connect to stories and that has been absent from mainstream education and training on mental health issues in a variety of disciplines (health, mental health, social work etc.).
- Importance of lived experience speakers in education and training in health/mental health disciplines, especially outside of designated Lived Experience spaces.
- Inclusion of both private and public education/training where reforms are proposed to reduce stigma and discrimination in an education context.

Health/Mental Health

- Acknowledgement that stigma of mental health/mental illness is often strongest in mental health and health disciplines which can contribute to or compound iatrogenic trauma.
- There should be improved, more efficient and transparent processes in place that allow consumers to report/rate workers and services; not only directly related to health/mental health, but other services consumers might access, e.g. Centrelink.
- Support workers with NDIS should be able to advocate for the consumer.
- Mental Health Law Centre and other advocacy/legal support services should be funded for people who do not identify as having a 'mental illness' in those terms, or for those who are voluntary inpatients.

Public Stigma

- There needs to be more visible and central avenues for the public to report stigmatising behaviour, attitudes, and practices such as a hotline or a website like SANE's 'StigmaWatch'.
- Encourage all media organisations to have focus groups for lived experience input into how mental health is represented in news, advertisements, film and television and other cultural texts.
- Further development of resources and media kits for News outlets to educate media staff on a range of mental health issues and how to represent/discuss them.

Self-Stigma

- Even among the consumer/lived experience community, the term 'self-stigma' and its implications is not widely known. In formal education, this is defined in some

mental health-related qualifications, but definitions should be explored and discussed for the broader community.

- Self-stigma and public stigma are inextricably linked – diverse representations of mental health in a variety of media contexts will contribute to how stigma is internalised and understood on a personal level.