MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

Submission on the (Draft) National Stigma and Discrimination Reduction Strategy

Acknowledgement of Country

The Mental Health Lived Experience Peak respectfully acknowledges and honours the Traditional Owners of the Lands and Waters throughout Queensland. We thank the Elders - past, present, and emerging – for their wisdom and survivorship. We acknowledge that First Nations Peoples have a unique experience of stigma and discrimination, particularly when their experiences involve mental ill-health, suicidality, and intergenerational social disadvantage and marginalisation.

Acknowledgement of Lived Experience

The Mental Health Lived Experience Peak would like to recognise people with a lived experience of mental ill-heath and suicidality who have endured societal, structural, public, and individualised stigma and discrimination. We honour people who have fought for change over many years, including the right to have a collective voice that challenges existing discriminatory practices and effects positive change within the systems that may have caused harm. We draw upon lived experience expertise and knowledge of our members to evidence necessary reforms, using organisational values of Safety, Respect, Intentionality, Integrity, and Outcomes.

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Key Insights

i. ***Reducing stigma and discrimination*** for people with lived and living experience of mental distress, ill-health and /or suicidality requires the leadership and knowledge of people most affected by it: those who are marginalised, disadvantaged, and excluded from society due to the ongoing effects of stigma and discrimination.

ii. ***Short, medium term, and long-term*** whole-of-societal planning such as that suggested in the *(Draft) National Stigma and Discrimination Reduction Strategy*, well implemented and monitored, carried strong membership confidence that a reduction of stigma and discrimination could occur.

iii. ***A human rights, person-centred, culturally responsive and holistic*** societal shift was described as crucial to support the systemic, structural, public and individual action plans recommended within the Strategy. Human rights and equity frameworks must be written into legislation and policy and have independent oversight, including by lived experience workforce.

iv. ***Lived experience workforce and leadership*** is critically important to shift the current societal and cultural conditions that support ongoing stigma and discrimination.

v. ***Structural stigma and discrimination*** remain a strong barrier to people's recoveries. This is particularly so within legal and financial systems where there is less confidence that change can and will occur (despite it being deemed as critically important).

vi. ***Evaluation, monitoring and public reporting*** of change processes are crucial to closing the quality improvement loop on recommended actions.

vii. ***Public media's role*** in the social movement to reduce stigma and discrimination is crucial, both through public education strategies and by reviewing and changing the ways that they currently reinforce stigma and discrimination.

viii. ***People with lived and living experience*** of stigma and discrimination due to their mental health status continue to carry the burden of internalised negative societal messages about who they are and what sort of lives they can lead. Advocacy, holistic support and working in partnership with people to enable their recoveries is critical to individual and community wellbeing.

Who are we?

The Mental Health Lived Experience Peak Queensland (MHLEPQ) is a new initiative funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health. Our organisation was created in July 2021 and moved to direct contracting with Queensland Health on January 1st, 2023 (formerly auspiced by the Queensland Mental Health Commission).

The MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system with specific focus on those who are disadvantaged and marginalised. Our work is based on the principles of equity, access, cultural safety, recovery, and human rights.

Our approach to this submission

Our submission to the *(Draft) National Stigma and Discrimination Reduction Strategy* (the Strategy) represents a collective lived experience-only perspective from MHLEPQ members. The submission was informed by our membership and a previous lived experience advisory group who contributed to the Parliamentary Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders.

All responding members have a personal lived or living experience of mental ill-health or distress, trauma and / or suicidality[1]. Adults aged between 30 and 59 gave their perspectives, representing First Nations Peoples, culturally and /or linguistically diverse people, males and females, and people living with developmental or intellectual disability and / or chronic illness or experience of neurodiversity. Direct quotes are embedded throughout the submission, either in double quotation marks in the body of the paragraph, or indented and in italics.

The MHLEPQ invited our members to complete an online survey that was based on the National Mental Health Commission (NMHC) survey 1[2], adapted for accessibility. Our organisational submission was based on the suggested consultation questions[3] for each of the four priority action areas[4], then sent back to the survey respondents for their input. Amendments were then made based on the feedback from the

[1] Alcohol and other drug users' perspectives are not directly represented
[2] https://haveyoursay.mentalhealthcommission.gov.au/provide-feedback-draft-national-stigma-and-discrimination-reduction-strategy/survey_tools/survey1
[3] Including: feasibility, enablers, barriers, effectiveness and gaps
[4] Priority 1: foundational actions; priority 2: structural stigma and discrimination; priority 3: public stigma; priority 4: self-stigma

responding members and the collective summary was finalised before uploading to the NMHC.

Discussion

General comments

Members described the need for strong leadership with actioning the Strategy, "a staged approach to rebuilding", and a cultural change toward "a compassionate and person-focussed approach to therapy and treatments". Increasing social inclusion and participation is best led by communities who know their own needs and are the best source of knowledge for their own unique context, which involves[5]:

> *improving neighbourhood environments, tackling bullying and discrimination in all settings, safe work and public places, and access to basic services like child care and self-help/ support networks.*

The importance of a principled approach to all four priority areas was noted, including but not limited to:

- Whole-of-society cultural change;
- Human rights and person-centred approaches, written into legislation and policy;
- Lived experience leadership;
- Lived experience workforce;
- Evaluation, monitoring and reporting of change processes.

Priority action areas

1. **To implement foundational actions across settings to address stigma and discrimination**

Participants believed that there was a high probability that strengthening human rights protections and accountability mechanisms would reduce foundational stigma and discrimination.

> *I think that strengthening human rights protections and accountability will significantly improve outcomes towards the reduction of stigma and discrimination because little legislative representation exists to protect and safeguard the rights of those living with mental illness.*

People were less inclined to believe in the capacity for more accessible complaints and appeals processes to make a difference because "any process can be

[5] Mental Health Lived Experience Peak Queensland (2022). Submission to the Queensland Parliament Mental Health Select Committee, accessed 25.01.22, p.26 of 34

overwhelming"; although there was hope that "enabling and giving accessibility to amplify voices of experience above the existing processes should improve the stigma towards mental health".

The proposed actions for workforce education and training were deemed highly likely to reduce stigma and discrimination, with one respondent saying:

> *This is a massive area of opportunity for dismantling stigma and discrimination because workforces are already places where we spend the most amount of time interacting with people.*

There was strong confidence that stigma and discrimination would decrease with the proposed changes to embed lived experience in leadership and advocacy, because "[it] always starts with leadership" and this action humanises the experience:

> *Embedding lived experience in leadership and advocacy can overcome stigma because it puts a face to the experience and we know this works because of the success of peer led working support groups. Humanizing the experience also influence a richer set of values towards more meaningful work in advocacy which reduces barriers to accessibility.*

The importance of Lived Experience Workforce for dismantling structures that continue to stigmatise and discriminate against people was affirmed:

> *Connecting with the Lived Experience Workforce supported me to shed the shame (and individual/ societal/ institutional stigma) that I carried.*

Feedback reflected less confidence and a mixed response about the positive effects of an improved evidence base, evaluation, and monitoring. For people reporting a 5-6/10 likelihood, they described not being sure about the likely impact, although they felt that "any advancement is good in gathering information". One person felt that evidence, evaluation, and monitoring could be expected to reduce stigma and discrimination "because people will see through example the improvement".

2. Actions targeting structural stigma and discrimination

Members described how critically important the proposed changes were for improved outcomes in the mental health system, the health system, *and* social services, although there was mixed confidence about improved outcomes in legal and financial services, "regarding insurance, life policies are not available for people with mental illness […] this is discrimination".

One member endorsed the strategy's "multifaceted approach. Focusing on the whole rather than a part" and another voicing the likely impact on 'downstream'

experiences: “[proposed changes] will decrease number of suicides we see and the flow on effect from suicide”. The crucial importance of a range of accessible cross-sector services was described:

> *I like that it’s about appropriate support. [An] Indigenous Australian may or would have different issues to the LGBT community with the common issue mental health*

A MHLEPQ lived experience advisory group highlighted the importance of a holistic approach to addressing the social determinants of mental health in a cohesive, whole-of-society strategy in their submission to the Select Committee Inquiry into improving mental health outcomes for Queenslanders[6]:

> *[Recommendation 14] Adopt a holistic approach to social and emotional wellbeing that encompasses the broader societal impacts of intergenerational trauma, institutionalized racism and discrimination, unemployment, access to services, physical health, education.*

The importance of proposed changes to financial services and insurance, and employment was wholly supported, indicating how crucial a whole-of-system approach to reducing stigma and discrimination at a structural level is:

> *Having a supportive environment where financial support is available will remove one, and at time’s the most significant barrier to reaching out for support*

Education and training was also considered crucial by members, to include all members of the ‘care community’ such as frontline and reception staff: “Education of rights, roles and responsibilities is paramount” said one, “Education leads to change”, said another.

While a reform in legal system support was affirmed as important, there was scepticism about the capacity for change in that field: “not sure how legal will go? As many who deal with that atm [at the moment] find it somewhat indifferent now. To me justice only exists in the dictionary”.

A few members described additional actions to reduce structural stigma and discrimination in the mental health system through:

- “Strong advocacy for those who can’t advocate for themselves”
- “Accountability for poor behaviours”

[6] Mental Health Lived Experience Peak Queensland (2022). Submission to the Queensland Parliament Mental Health Select Committee, accessed 25.01.2023, p.3 of 34

- "A reporting system that notifies a requirement (or mandate) for 'social upskilling training'"

3. Actions targeting public stigma

There was full support for any action resulting in a social movement to reduce stigma and discrimination, particularly associated with addressing current representation and reporting of mental ill-health in the media.

> *Media representation plays a great role in overcoming perceptions of mental illness and we have been lucky to have so many great examples in entertainment. Programs on SBS such as 'How Mad Are You' or 'Wakefield' on ABC accurately depicted the diversity of mental ill-health without further enforcing stereotypes.*

Culturally safe training and educational initiatives were also seen as imperative to reducing barriers and stereotypes, although this was tempered with the advice that legislation was an important part of accountability for implementation and evaluation: "Training and education are always powerful tools in improving issues however, there unfortunately sometimes need to be a "big stick" there […] that's where legislation comes in".

4. Actions addressing self-stigma experienced by people with lived experience

> *I think self-stigma is still a big area of opportunity because there still needs to be a lot of support and coaching to get someone to a level of confidence to manage this independently. In some ways self-stigmatization can be even more damaging to perpetuate stereotypes because someone might not be equipped with the right skills to nourish themselves.*

Summary

People with lived experience of stigma and discrimination relating to mental distress, ill-health and /or suicidality affirm the call to action on the NHMCs long term strategy. Our members describe strong confidence in the capacity for the proposed action changes to make meaningful impact on reducing stigma and discrimination. This is tempered by the perspective that measurable change will occur if (and only if) there is implementation of, and accountability to the Strategy, resulting in a cultural shift of people at different levels of society and across social sectors.

MHLEPQ thank the National Mental Health Commission for their efforts on this very important consultation and strategy. For people with lived and living experience of mental ill-health, suicidality and social disadvantage who endure stigma and discrimination, the compounding effects are notably impactful. Whole-of-society

benefits of a long-term vision for reducing stigma and discrimination are possible and if actioned, will create more equitable, just, respectful, and dignified communities that uphold individual human rights. We express our desire for ongoing contribution towards the campaign, focused on transformational change at the societal, structural, public, and individual levels.

Future communication about this submission or associated matters can be made with:

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