Submission to the National Draft Strategy to Reduce Stigma and Discrimination

Key Recommendations

1. *Amend the language used in the Strategy to increase clarity and articulate the difference between a person who is experiencing psychosocial disability and a person who is using their lived experience of psychosocial disability in a designated Lived Experience work-role.*

2. *Consider a Strategy action to amend the National Health Practitioner Regulation Law to include a fourth category of notification that addresses stigma and discrimination, as they relate to mental health.*

3. *As a short-term priority action within the Strategy:*

    - *obligate mental health services to address the cultural drivers within them that lead to stigma and discrimination related to mental health and, consequently, unsafe service provision*
    - *duplicate action 2.2h in the context of mental health services, such that funding arrangements are contingent upon mental health services demonstrating they can provide a safe and empowering service for the people who use them.*

4. *Ensure that the Strategy requires the National Professional Association for Lived Experience Workers (as set out in action 2.1g) to be developed in consultation with all existing Consumer Peaks across the States and Territories, as well as the soon to be established National Consumer Peak.*

5. *Clarify whether the additional 'lived experience' roles to be developed (as part of actions 1g – 1h) are:*

    - *an action intended to improve the Strategy or an outcome of the Strategy*
    - *designated 'lived experience' roles where people use their lived experience as a job requirement; and*
    - *additional positions for people who experience psychosocial disability.*

6. *Consider a Strategy action to explore accreditation models to ensure organisations who are funded to employ increased numbers of people with psychosocial disability are accredited to do so.*

1. Clarify the language used in the Draft Strategy

The term 'lived experience' seems to be used throughout the Draft Strategy to denote people who have experience of psychosocial disability. This term can be confusing when used to refer to increasing job opportunities *for* people living with psychosocial disability (for example, in 2.3j) as opposed to increasing opportunities for people to *use* their lived experience of psychosocial disability in a designated Lived Experience role.

Recommendation 1*:*
Amend the language used in the Strategy to increase clarity and articulate the difference between a person who is experiencing psychosocial disability and a person who is using their lived experience of psychosocial disability in a designated Lived Experience work-role.

2. Bring stigma and discrimination specifically within the remit of AHPRA to help increase the accountability of health practitioners

We know from our work with consumers that stigma and discrimination in relation to mental health can also be driven by the attitudes and practices of health practitioners. While the long-term goal is attitudinal change, short-term efforts to create behaviour change among the mental health workforce could improve consumer experiences sooner.

At worst, stigma and discrimination among mental health practitioners and in related service settings can reinforce ideas that people facing mental health challenges are dangerous, need to be locked up, cannot make useful decisions for themselves, and need paternalistic styles of care.

We believe that bringing mental health-related stigma and discrimination directly under the jurisdiction of the Australian Health Practitioner Regulation Agency (AHPRA) would increase practitioner accountability and help tackle stigmatising and discriminatory behaviours among health professionals.

Recommendation 2:
Consider a Strategy action to amend the National Health Practitioner Regulation Law to include a fourth category of notification that addresses stigma and discrimination, as they relate to mental health.

3. Address the cultural drivers within mental health services that lead to stigma and discrimination and, consequently, unsafe service provision

Action 2.1 states that mental health services should be required to provide safe and empowering services for the people who use them.

VMIAC members who participated in the National Mental Health Commission consultation supported the idea that the Strategy could direct the use of both softer educative processes and harsher regulatory processes/instruments to ensure accountability among mental health services for the stigmatising attitudes and behaviours of their mental health practitioners. Many participants expressed these things could co-occur in the early stages of the Strategy implementation and should also occur within the mental health system itself.

Mental health service providers set the tone for community perceptions of mental health and psychosocial disability due to them being positioned as experts in how people with mental health issues should be treated.

While we acknowledge elements in the Draft Strategy to address stigma by training and awareness-raising initiatives within tertiary education and professional accreditation bodies

(such as those listed in pp. 73-78), this does not address the variations in culture that exist within each service on the ground.

For example, all services in Victoria operate under the same legislation, however, have variable rates for the use of seclusion and restraint. Each service needs to be accountable for improving its own culture to minimise stigma held by staff and discriminatory treatment.

Furthermore, Action 1.4 (pp. 24 – 25) and Action 3.1b relates to training key cohorts and workforces (including mental health professionals) to build their capacity to deliver services free from stigma and discrimination. This action can occur simultaneously alongside Priority 2.1 (pp. 30 – 32) that requires the mental health system to provide safe and empowering environments for people seeking services.

By combining stronger accountability mechanisms (such as AHPRA) *with* educative, contact-based initiatives to train workers as outlined in Actions 3.1 (p. 76), there is no reason why the mental health system cannot become a safe place for consumers as a foundational step. In fact, it is critical that this Action is amended to become a short term, foundational step.

As was acknowledged in the consultations, training students who are studying to become mental health professionals (as set out under Action 3.1d) can only be effective if the workforce that they ultimately enter models the same beliefs and attitudes. If the workplace culture is full of stigma and discrimination, training up-and-coming mental health professionals in anti-stigma and non-discriminatory practice will not be effective because, ultimately, they will learn to adopt the culture of their workplaces.

Additionally, the Strategy notes (p. 76) that pre-existing Lived Experience roles within services can be used to play a key role in delivering learning content. While this may be effective in a service that has a positive culture towards people with Lived Experience or experiencing psychosocial disability, it will not be safe for Lived Experience workers to train their colleagues if the culture of that workplace is stigmatising and discriminatory.

Furthermore, it should not fall to people working in Lived Experience roles in mental health services, who often already experience stigma and discrimination from within their workplace (as is noted on p. 33) to educate their colleagues on how not to stigmatise, or discriminate against, them.

VMIAC believes that aspects of Action 2.1 should be explicitly included at a foundational level of the Strategy and framed to prompt examination of individual service cultures. This would distinguish between individual 'service cultures' from 'structural drivers', such as exclusion of diverse populations (Aboriginality, ethnicity, language, LGBTIQ identities, etc.) or legislative provisions, policies or frameworks that lead to unsafe services (as addressed in pp. 30 – 32).

We propose the insertion of an additional Action under Priority Three (public stigma), which requires services to immediately address the specific cultural drivers of stigma and discrimination at their workplaces that lead to unsafe service provision.

Recommendation 3:
As a short-term priority action within the Strategy:

- *obligate mental health services to address the cultural drivers within them that lead to stigma and discrimination related to mental health and, consequently, unsafe service provision*
- *duplicate action 2.2h in the context of mental health services, such that funding arrangements are contingent upon mental health services demonstrating they can provide a safe and empowering service for the people who use them.*

4. Establish a National Professional Association for Lived Experience Workers in Partnership with Consumer peaks

Action 2.1g provides for the establishment of a National Professional Association for Lived Experience Workers, and proposes this Association provides training, accreditation, support, and advocacy on Lived Experience workforce issues.

VMIAC notes most jurisdictions have a consumer peak body, many of whom already provide some of these functions. We also note recent announcements by the Commonwealth to establish a National Consumer Peak.

Until now, and in the absence of a national consumer peak, these organisations built by and for people with Lived Experience of mental health challenges have played a vital and connecting role, building close relationships and trust with fellow consumers, as well as our consumer workforces.

This alliance of consumer peaks has long been cognisant of the on-the-ground impacts on consumers due to the funding mix of mental health services in Australia. We have been supporting consumers with issues arising from how their State or Territory intersects with the Commonwealth on mental health and related services (such as the NDIS), as well as around other advocacy and complaints bodies.

To avoid duplication of expertise, and in recognition of the longstanding relationships between consumers, consumer workforces and their respective Consumer peaks in each State and Territory; this Alliance has advocated for a key role in determining the detail of how the National Mental Health Consumer peak body is to be established, constituted, and governed, as well as its core functions and deliverables.

Similarly, VMIAC proposes any National Professional Association for Lived Experience Workers be developed in consultation with, and alongside the consumer peaks in all the States and Territories, as well as the soon to be established National Consumer Peak.

Recommendation 4:
Ensure that the Strategy requires the National Professional Association for Lived Experience Workers (as set out in action 2.1g) is developed in consultation with existing Consumer Peaks across the States and Territories, as well as the soon to be established National Consumer Peak.

5. Clarify the type and purpose of additional Lived Experience roles to be created

The Draft Strategy states that work will be done to increase the number of Lived Experience roles (*actions 1g and 1f*), however it is unclear whether this is an action to contribute to reducing stigma and discrimination, or an outcome of actions to reduce stigma and discrimination.

It is also important to be clearer on the type and purpose of these roles. Are they to be a contact-based initiative, where there will be an expectation that workers also share their lived experience with their workplaces? Or will these additional roles be put in place to support increased employment for people with psychosocial disability?

Recommendation 5:
Clarify whether additional 'lived experience' roles to be developed (Actions 1g–1h) are:

- *an action intended to improve the Strategy or an outcome of the Strategy*
- *designated 'lived experience' roles where people use their lived experience as a job requirement; and*
- *additional positions for people who experience psychosocial disability.*

6. **Develop a stigma reduction and anti-discrimination accreditation model**

Numerous actions throughout the Draft Strategy refer to increasing Lived Experience roles across multiple sectors, and not just in mental health.

The Strategy implies (*on p.13*) that attitudinal changes will follow the implementation of compliance requirements mandated by legislation. It states that the Strategy will compel behavioural change through a range of compliance measures, even where there is no attitudinal change. While compelling behavioural change is important, this can only ever address discrimination. Whereas stigma relates to beliefs and attitudes, which we cannot regulate or compel to change.

Our concern lies where lags arise in implementing or communicating legislative changes, or where inconsistencies exist in the uptake of reforms. Employers must be required to demonstrate minimum levels of understanding and compliance with new, strengthened anti-discrimination and human rights laws.

VMIAC believes mandatory requirements for accreditation to build organisational readiness could be a useful pre-requisite for funding where such funding specifically supports employers to hire in designated Lived Experience roles and workers with psychosocial disability.

We believe this measure could protect staff from stigma and discrimination, especially in the private sector.

For example, action 2.4a refers to incorporating lived experience workers into financial and legal services in the short term, to assist clients who are navigating these service systems. We believe employers in these fields must demonstrate an understanding of, and compliance with, anti-discrimination laws to protect these workers.

Recommendation 6:
Consider a Strategy action to explore accreditation models to ensure organisations funded to employ increased numbers of people with psychosocial disability are accredited to do so.