Submission to the Productivity Commission

Mental Health and Suicide Prevention Agreement Review

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Contents

Overview

We welcome the opportunity to contribute to the Productivity Commission Review of the Mental Health and Suicide Prevention Agreement. We are responding to the following Terms of Reference:

- the impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity.
- the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved.

In making this submission, we are focussing on s113 and s114 of the National Agreement in relation to stigma reduction and discrimination.

Stigma Reduction
113. The Parties commit to reducing stigma and discrimination for those affected by mental ill-health by:

a) responding proactively and providing leadership when stigma or discrimination is seen
b) empowering consumers and carers to speak about the impacts of stigma and discrimination; and
c) contributing to promotion and normalisation of help seeking.

114. Parties will work in partnership to develop the National Stigma and Discrimination Reduction Strategy, agreed by the National Cabinet. Parties will work together to consider and implement relevant actions of the National Stigma and Discrimination Reduction Strategy once finalised.

We also note that consideration and implementation of the Strategy once finalised was a stipulated output of the Agreement (cl 27(g)).

As the Productivity Commission's 2020 Mental Health Inquiry Report noted, government plans to reduce stigma and discrimination have shown limited progress. Five years later, there is still limited progress under the National Agreement. While a National Stigma and Discrimination Reduction Strategy (the Strategy) has been developed, it has not yet been released or implemented as such. Consequently, there are no mental health programs and services delivered that are targeted at stigma and discrimination as part of a comprehensive and systematic national effort. Stigma and discrimination in mental health still remain a pressing issue

This submission provides an overview of the development of the Strategy and the continuing need for a strategic approach to stigma and discrimination reduction in mental health. It also outlines best practice opportunities for further reform.

About us

We are all members of the former Steering Committee for the Strategy, serving on the Committee from 2021-2023. The Committee's role was to provide advice and support the National Mental Health Commission in developing the Strategy.

Kevin Bell AO was Co-Chair of the Steering Committee. He is a leading human rights jurist and senior advocate committed to human rights, equality and access to justice. He is the former Director of the Castan Centre for Human Rights Law and served as a Commissioner on Victoria's YooRrook Justice Commission.

Tim Heffernan was Co-Chair of the Steering Committee. He has been Deputy Commissioner of the NSW Mental Health Commission since 2018. Before that, he was a member of the Commission's Community Advisory Council from its establishment in 2014. He is an experienced Consumer Peer Worker and is the Chair of BEING.

Maria Katsonis has been using her lived experience of mental ill health as a consumer advocate for 15 years with Beyond Blue, Mental Health Australia and the National Mental Health Commission. She is the Deputy Chair of the Victorian Collaborative Centre for Mental Health and Wellbeing and an Industry Fellow, Public Policy at the University of Melbourne.

Mark Orr AM is the Chief Executive Officer of Flourish Australia. He has worked extensively in disability services and guardianship, as well as championing HIV prevention, care and support, mental health, and LGBTI health care and rights.

The authors would like to acknowledge the contribution of Dr Chris Groot to this submission. Dr Groot is the Director of the Mental Illness Stigma Lab in the Melbourne School of Psychological Sciences at The University of Melbourne.

The National Stigma and Discrimination Reduction Strategy

Background

Action 8.1 in the Productivity Commission's 2020 Mental Health Inquiry Report recommended that the National Mental Health Commission should develop and drive a National Stigma Reduction Strategy designed to reduce stigma towards people with mental illness.

In 2020, the National Mental Health Commission was tasked by National Cabinet with developing the Strategy. It was to be the first government-led national strategy to take a comprehensive and systemic approach to addressing mental health-related stigma and discrimination in Australia

Development of the strategy

The Strategy was developed with significant input from people who experienced mental health-related stigma and discrimination. This collaboration ensured diverse perspectives shaped the Strategy.

In addition to the Steering Committee, a series of Technical Advisory Groups were also established to guide the development of the Strategy. These groups considered self-stigma, public stigma, structural stigma and discrimination, and measurement.

A 12-week public consultation period was held from 9 November 2022 and closed on 1 February 2023.

The strategy in brief

The purpose of the Strategy was to outline a long-term vision for an Australian society where stigma and discrimination based on mental ill health are no longer barriers to people living long and contributing lives.

The vision was:

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

The Strategy set out clear priorities and actions to:

- 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 concentrated on stigma and discrimination reduction in the following areas:

- mental health system
- health system
- justice, legal, financial services and insurance
- education and training

- employment
- social services, disability support services and housing.

The Strategy prioritised actions that could be achieved or substantially progressed over a five-year horizon. The expected high-level outcomes were:

- societal structures, institutions and workplaces are safe and inclusive for people with personal lived experience, with existing and new supports fully realised.
- organisations and individuals are held accountable for preventing stigma and discrimination stigmatising public attitudes are reduced and capacity, capability, attitudes and behaviours among key workforces are improved.
- opportunities and evidence around resisting self-stigma are strengthened.
- evidence base is built for stigma and discrimination initiatives.

The draft Strategy is no longer publicly available.

Continuing need for a strategy

The National Mental Health Commission delivered the draft Strategy to Government in 2023 for its consideration.

In June 2024, we were advised that the Minister for Health and Aged Care has asked the Department of Health and Aged Care to consider actions from the Strategy and to share the Strategy with senior officials across governments to support consideration of joint action in the reduction of stigma and discrimination.

We were also advised that the National Mental Health Commission would keep a watching brief on stigma and discrimination as part of its broader role in national monitoring of mental health and suicide prevention.

It is unclear from publicly available information if any actions under the Strategy have been progressed. The 2022- 2023 Annual National Progress Report Summary of the National Agreement does not make any mention of initiatives to address stigma and discrimination.

There are pressing and well understood reasons for developing and implementing a national strategy for preventing and reducing stigma and discrimination. These informed the recommendation of the Productivity Commission and terms of the Agreement on this subject, which have not been acquitted. The reasons continue to exist today. The case for a strategy is as strong as it ever was. We support the continuation of efforts towards developing and implementing a strategy, building on the one that is before government.

Impact of programs and services under the National Agreement to Australia's wellbeing and productivity

There are currently no coordinated initiatives being delivered to address stigma and discrimination in mental health under the National Agreement. Additionally, there is no publicly available evidence that Parties to the Agreement have responded proactively or provided leadership when stigma or discrimination is seen. Neither is there evidence to show that they have empowered consumers and carers to speak about the impacts of stigma and discrimination.

New South Wales and Queensland are undertaking some work in stigma reduction as are Australian organisations such as Beyond Blue, SANE, LIVIN, Batyr, Shapes and Sounds and others. However, their individual and collective impact is limited. This is largely due to the lack of a guiding, evidence-based, best-practice framework specifically designed for and by Australians. Additionally, there is no single peak body driving a coordinated, national effort to tackle stigma, which further hampers progress.

As a result, opportunities are being lost to improve Australia's wellbeing and productivity through the National Agreement. As the Productivity Commission's Mental Health Inquiry Report noted, "The stigma associated with mental illness and suicide can limit people's ability to engage socially and to feel included, and can lead to discrimination, social exclusion and a reluctance to seek care." (Productivity Commission 2020).

Recent data on mental health stigma and discrimination

Mental health stigma and discrimination is still prevalent in Australia and is supported by the outcomes of a National Survey of Mental Health-Related Stigma and Discrimination conducted by the Behavioural Economics Team of the Australian Government in the Department of Prime Minister and Cabinet. This research informed the development of the National Strategy.

The findings estimated over four million Australians experienced mental health-related stigma and discrimination in the prior 12 months. Experiences of discrimination in the workplace were also common, with one in three people reporting unfair treatment in the workplace. People who experience more complex mental health problems such as schizophrenia were disproportionately affected by stigma and discrimination, with nine out of ten reporting any kind of discrimination and eight out ten facing difficulties in finding a job. Stigma also had an impact on close interpersonal relationships BETA survey with one in three people experiencing stigma and discrimination in their families and friendships (BETA 2022). These close interpersonal relationships are critical to an individual's wellbeing.

Experiences of discrimination can have detrimental consequences. The research found people with discriminatory experiences were more than twice as likely to report they had avoided accessing healthcare at some point in the last 12 months because of how they anticipated people might respond to their mental health problem. They were also three times more likely to have decided not to apply for employment opportunities. (BETA 2022).

The BETA survey findings suggest the following in relation to the different forms of stigma.

Public stigma

More than 60% of Australians are unwilling to interact with someone living with schizophrenia. This desire for social distance spanned everything from living as a neighbour, to being a co-worker or friend, to even just socialising for a dinner. The damage this causes for people living with psychosis cannot be underestimated. Similarly, more than 60% of the sample thought people with lived experience of psychosis or BPD were unpredictable and similarly high rates displayed pity rather than empathy. This highlights the undertone of power imbalance, judgment, emotional distance and perceived reduction in agency.

Structural stigma

There were high rates of support for addressing stigma and discriminations with 83% agreeing that more needs to be done to reduce discrimination against those with mental ill-health.

Self-stigma

Fifty-eight percent of people with lived experience felt like they should be able to 'pull themselves together' while 59% avoid talking about their mental health issues.

Anticipated stigma

The potential to be stigmatised and experience discrimination in the future can be a factor people consider when deciding whether to engage in certain activities. Seventy-eight per cent reported concealing their mental health problems in anticipation of negative responses from others and 42% reported having stopped themselves from accessing healthcare.

Opportunities under the National Agreement to adopt best practice approaches

Workplace mental health

Stigma delays help-seeking and timely access to assessment, treatment, and support. This prolongs and exacerbates problems, and also inhibits opportunities for recovery. In turn, this means larger amounts of resources are required with a significant impact on the productivity and economy of Australia. This includes:

- absenteeism which costs Australia $12.8 billion per annum (MHA Investing to Save Report 2018).
- the loss of eight million working days each year due to mental ill-health (national Mental Health Commission 2021).

Addressing stigma will reduce this burden on the nation's economy. A 2016 RAND Corporation study on a state-wide stigma-reduction campaign in California found that for every US$1 invested, the state could expect US$36 in economic benefits through higher tax collections. If sustained over several decades, the campaign could generate US$1,251 in economic benefits for every US$1 invested. These benefits stem from increased employment and workplace productivity as more individuals are more likely to seek treatment and to recover sooner and more effectively.

When workplace mental health initiatives with strong stigma reduction components were introduced in 10 Canadian workplaces, median annual return on investment on each dollar spent was CA$1.62. Companies with stigma initiatives in place for three or more years has a median annual ROI of CA$2.18 (Deloitte 2019).

WHO Mosaic toolkit to end stigma and discrimination in mental health

In 2024, the World Health Organisation launched a new toolkit to support evidence-based activities aimed at reducing stigma and discrimination in mental health. The development of the toolkit was in response one of the recommendations of the Lancet Commission on ending stigma and discrimination in mental health. This umbrella review of 216 systematic reviews synthesised the best available evidence on what it takes to reduce stigma and discrimination.

Stigma is often framed in terms of mental health literacy. By addressing misinformation about mental health conditions, it is assumed you can reduce prejudice and make it less likely for someone to discriminate. However, improving knowledge does not necessarily reduce prejudice. According to the Lancet Commission, the best way to reduce stigma is through social contact – prejudice-reducing interactions between people living with mental health conditions and people without a condition. Here the focus is on changing attitudes and improving behaviour.

The toolkit advocates embedding three core principles into any anti-stigma activity:

1. **Leadership or co-leadership by people with lived experience**. People with lived experience should be involved from the beginning of any anti-stigma work,

preferably in leadership or co-leadership positions where their contributions are valued equally to any other expertise shaping the activities

2. **Social contact**. Evidence shows that the best way to reduce stigma and discrimination is through social contact between people with and without the stigmatised feature. Social contact is not any kind of contact. It has distinct features including disconfirming stereotypes and dispelling myths; building skills in behaviour change; opportunities for sustained interaction; and an emphasis on recovery.
3. **Inclusive collaborations.** In addition to strong partnerships with people with lived experience, stigma reductions programs tend to have greater impact when they are built on strong collaborations with a wide variety of groups in the community.

The toolkit then sets out a four-step process, incorporating these principles, to develop programs to reduce stigma. It is supported by 11 case studies from around the world including India, China and Denmark.

The release of the toolkit postdates the development of the National Strategy. It provides an opportunity to revisit the Strategy and consider the development of a practical, example-driven implementation document similar to the toolkit. This would include:

- stigma reduction implementation principles
- case studies and examples
- decision trees to help individuals, organisations and communities adapt the strategy to local needs
- concrete templates and checklists for monitoring progress.

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