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Draft National Stigma and Discrimination Reduction Strategy

Submission

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Suicide Prevention Australia

Introduction

Suicide Prevention Australia was provided with a copy of the Draft National Stigma and Discrimination Reduction Strategy (the strategy) dated 9th November 2022. The Commission has requested feedback on the strategy before 1st February 2023. The Commission is especially soliciting comments regarding the feasibility, enablers, barriers, and effectiveness of the strategy. The Commission is also asking for submissions to highlight any omissions from the strategy.

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We have over 350 members representing more than 140,000 employees, workers, and volunteers across Australia. We provide a collective voice for service providers, practitioners, researchers, local collaboratives, and people with lived experience.

Over 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Over 7.5 million Australians have been close to someone who has died by or attempted suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

The draft was developed in response to the Productivity Commissions Inquiry into mental health which recommended that “the National Mental Health Commission should develop and drive the implementation of a renewed national long-term stigma reduction strategy. This work has been reflected in other government policy such as the National Mental Health and Suicide Prevention Agreement and the Fifth Mental Health and Suicide Prevention Plan 2017-2022 which require governments to take action to reduce stigma and discrimination towards people with mental illness.

The strategy puts forward actions along a time continuum with short-term being actions within 1 year, medium-term 1 to 3 years while long-term 3-5 years.

The strategy establishes a vision of “an Australian community where everyone has equal dignity, value and respect and is able to live a life of meaning and purpose free from mental health-related stigma and discrimination”. This vision is supported by 5 principles base in upholding the dignity and human rights, autonomy, agency and voice, respect of roles as consumers and cares in the system and an approach based in cultural safety and an understanding of context. Finally, the principles call for accountability measuring change over time.

Actions called for in the strategy are structured across four priority areas:

1. Foundational change
2. Structural Stigma
3. Public Stigma
4. Self-stigma

The plan is summarised in a program logic-style table identifying how actions are expected to lead to changes which will produce benefits in the form of reduced stigma and discrimination.

Despite the stratification of action across the four priority areas, the strategy acknowledges that several actions are foundational across all four priority issues and do not fit neatly into a single priority area. These include:

- Public attitudes
- Lived Experience leadership
- Changing focus to a rights-based approach
- Workforce training
- Evaluation and monitoring of change

The commentary in this document is to be understood from a suicide and suicide prevention perspective only and is not an attempt to provide commentary on stigma reduction for persons with mental illness or alcohol and other drugs users.

Summary of Recommendations

General Comments:

1. A clearer definition of key terms such as Mental Health, Suicide and Suicidality
2. Clarify that suicide is not on a continuum of mental health, but a strategy engaged to deal with a mental health situation
3. While most recommendations in the strategy can apply to both mental ill-health and suicide stigma, it must be noted that suicide stigma is different, and it is problematic to treat these roots for stigma as if they are always the same
4. A suicide specific stigma and discrimination reduction strategy to supplement this strategy should be developed under the National Suicide Prevention Strategy

Priority Area 1:

5. A focus on accountability in the mental health system should be based in restorative justice approaches
6. Consideration the different stages of development of Lived Experience peer workforce and leadership capability between Mental Health, Suicide Prevention and D&A sectors in the call for Lived Experience representation in leadership positions

Priority Area 2:

7. Mental health support must be trauma informed, and trauma assessment is best done by a trained peer worker
8. Risk assessment and risk stratification of people experiencing suicidality is stigmatising and should be avoided in health care settings.
9. Safe spaces should be a significant alternative to medicalised care where an acute medical intervention is not required, ranging from informal to structured and formal.

Priority Area 3:

10. Any public campaigns to reduce stigma and discrimination (building social movement) must be specifically targeted towards the different areas of mental ill-health, suicide and Alcohol and Other Drugs (AOD)
11. Public exposure programs for reducing stigma and discrimination around suicide should have a combined focus of suicide prevention skills and suicide lived experience leadership
12. Suicide understanding and suicide intervention skills should be specifically taught in all health professional training courses

Priority Area 4:

13. Include measures to reduce self-stigma amongst those bereaved by suicide

General Comments

The Mental Health Commission is to be congratulated on a very well-constructed and comprehensive strategy. Stigma and discrimination is complex and multidimensional. It is based in history, culture, power, and discourse. It is collective, public, and personal at the same time. Any structure used to discuss a topic as complex as stigma and discrimination will have it limitations. This draft strategy is not an exception, but the structure chosen for the document strikes a very good compromise and allows for sufficient logic to make compelling arguments from the general to the specific, from fundamental conditions to structural, public, and self-stigma. This logic is also maintained within each priority area. We applaud the Commission for undertaking appropriate consultation in the development of this work.

The strategy highlights that “language matters”. However, the document lacks a consistent definition of fundamental terms perhaps most noticeably “mental health” (mental ill-health is defined but not widely used in the document). There are two ways of interpreting ‘mental health’:

- popularised meaning of mental health being an alignment with mental illness and mental ill-health; and
- the WHO meaning as a positive term (Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community[1]).

In the vision of the document, it refers to “mental health-related stigma”, but if mental health is understood as a positive term wherein describing what is required to live a contributing life, then everyone in the community experience mental health. As the Strategy is focused on stigma based in mental ill-health or poor mental health, it’s important the language used is clarified and consistent throughout the Strategy.

[1] WHO 2022 Mental Health: Strengthening our response: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

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The softness in definition further complicated the inclusion of suicide and suicidality in the document scope and could be considered an expression of stigma towards people experiencing suicide and suicidality. The strategy discusses a move from a categorical framing of mental health to a continuum framing of mental health. Such framing works very well for mental health when understanding mental health in the same positive way as physical health, i.e., people may have good or poor physical health, and this will increase or decrease susceptibility to other health conditions and illnesses. However, health conditions and illnesses will also impact on a person's general physical health. This framing strikes a balance between agency and environment impact for the individual.

The concept of a continuum is more complex in suicide and suicide prevention. The idea that there is a continuum from mental distress to suicide ideation, suicide attempts and suicide deaths is debated and contested.

Furthermore, it could suggest that "suicide" is to be found somewhere on the mental health continuum from great mental health to poor mental health or illness. Suicide is not an illness or condition but a behaviour. Therefore, suicide is to be seen as a reaction to where the person is on this mental health continuum rather than being part of the continuum. This distinction is important as it is this conflation that is driving much of the medicalisation of suicide.

A significant measure for reducing stigma and discrimination towards people experiencing a suicide crisis will be direct and un-hindered access to non-clinical support such as safe-spaces and a broad and comprehensive person-centred system of aftercare.

The inclusion of suicide on the continuum where severe mental illness is at one end while social wellbeing is at the other ignores the fact that for some people, self-harm behaviours are a coping strategy for significant mental health stressors. When dealt with as "the problem" that needs to be addressed, people in distress may be denied something that can help them cope during difficult times. It is this difference that require suicide and suicide stigma to be considered as separate although closely related to stigma and discrimination based in mental ill-health.

The strategy deals with a range of matters that will reduce stigma and discrimination for people experiencing mental ill-health, suicidality and treatment for AOD related issues and will therefore also address some of the stigma experienced by people with lived experience of suicide as either survivors, carers or bereaved. There are unique experiences to suicide that impact stigma and discrimination. We recommend a separate suicide specific stigma reduction strategy is flagged in this document for later development, potentially under the upcoming National Suicide Prevention Strategy. .

Priority 1: Implement foundational actions to address stigma and discrimination.

The strategy calls for a strengthening of human rights and anti-discrimination legislation. This is clearly both required and beneficial. However, great care should be taken in seeking legislation or a human rights charter as the solution. For example, the *Victorian Charter of Human Rights and Responsibilities Act 2006* has not prevented legislation with the peculiar provision where a person exposed to involuntary care is said to have the capacity to consent

to treatment, but not the capacity to decide not to be treated. When combined with other provisions of the strategy, strengthened human rights for people experiencing mental health crisis is clearly beneficial in reducing stigma and discrimination.

More important is the call to improve accountability mechanisms particularly where restrictive and coercive practices are used in the system. Accountability mechanisms should be embedded in a restorative justice framework. The current system of accountability leads to an adversarial approach, with minimisation of claims and cover-ups.

We welcome the call for embedding lived experience in leadership and advocacy in the Strategy. The United Nations Convention on the Rights of Persons with Disability states that people with lived experience be consulted and actively engaged in developing legislation and policies about them. The Convention includes people with mental illness, but it is unclear that this Convention applies to people without diagnosed mental illness or suicidality. It is important that any move towards embedding lived experience structurally in leadership and advocacy acknowledge the diversity of lived experience, including the fundamental differences between lived experience as a mental health services consumer or carer, of suicide as a survivor, carer or bereaved, or a person with lived experience of alcohol and other drugs use behaviours that cause harm, or use of alcohol and other drugs that do not cause harm.

This point is closely linked to the call for valuing and developing a lived experience workforce. The strategy specifically calls for a Mental Health workforce however the document should clarify that either the strategy only applies to Mental Ill-Health related stigma and/or make it clear that the workforce for suicide prevention and AOD is separate and different although can overlap in some areas.

Priority 2: Reduce Structural Stigma and Discrimination

The strategy discusses equity of access to quality health care for all. This requires a safe and empowering environment for all in the system. The focus in mental health care is still psychiatry and a mental illness paradigm. Access to care is not just access to any care but access to appropriate care. A change from a psychiatry centred model considering context as incidental to diagnosis, and a focus on context and community with diagnosis as incidental will broaden the view of care. A meaningful change from psychiatric focused care supported by community towards community-based care supported by psychiatry will ensure better and more suitable care.

This care needs to consider cultural safety but also needs to be trauma informed. Types of trauma to consider include intergenerational trauma (commonly experienced by First Nations people), domestic violence, discrimination such as that experienced by the LGBTIQ+ community, and trauma inflicted by past care particularly where such care has involved restrictive practices. True trauma informed care requires different modes of assessment and engagement than what is currently applied in the biomedical system. Well trained peer workers in mental health, suicide prevention and AOD will be well placed to provide the appropriate assessments of past trauma to inform appropriate and culturally safe care.

The strategy calls for the elimination of restrictive practices in the mental health system. People experiencing acute suicidality are often exposed to restrictive practices. This is often done as a risk mitigation strategy for the service provider rather than the person requiring

care. Doing a "risk assessment" on or for a person in suicidal crisis is inherently stigmatising and allocating resources based on a risk matrix rather than care need is inherently discriminatory. In terms of suicide assessment restrictive practices are used in lieu of understanding the person and their context. Use of restrictive practices causes harm and violates a person's human rights and self-agency and acts as a deterrent for future help-seeking. Mental health service providers should not assess risk but seek to understand situational factors and pain jointly with the person experiencing suicidality. Risk assessments for suicidality focused on risk stratification (High, medium, low etc) should not be conducted as they are focused on doing "to" the person rather than doing "with" the person. Support for people with suicidality should be done through engagement by developing a joint understanding of pain and need for safety.

This change in focus from diagnosis to understanding is particularly important for suicide prevention. Suicide as a behaviour can be understood, often in the context of the person's situational circumstances and sometimes in the context of their mental health diagnosis. Current care is diagnosis focused and thus often denies the situational context of the person. The definition of suicide as a mental health condition is stigmatising in itself, as it implies that a person's suicide thoughts are irrational and due to a cognitive deficit. For many people suicide ideation is considered a logical part of problem solving of complex problems and pain relief. At a semantic level suicide ideation will always be an expression of poor mental health but not always mental illness. An expansion of the concept of safe spaces across the community which includes different levels and availability as a significant alternative to medicalised care would assist in breaking down stigma.

The strategy is commended on its discussion on social determinants (including legal, work, and financial services) and the confounding of stigma and disadvantage experience generally into mental health and suicidality.

Priority 3: Reduce Public Stigma

Public stigma and structural stigma are closely related. Much of the structural stigma is underpinned by public stigma and much of the public stigma is based in the observed structural stigma.

Reduction of stigma is problematic in suicide prevention. Stigma is based in ignorance and fear. Fear is an important preventative factor for suicide while ignorance can be a barrier to support. A stigma reducing campaign for mental health will inevitably focus on normalising mental ill-health and crisis where normalising suicide behaviours is highly problematic.

An anti-public stigma campaign for suicide prevention for suicide (and AOD) will need to be specifically designed and implemented for that purpose.

The contact-based approaches must be separate for mental health, suicide and AOD. While mental health approaches are likely to be most effective when focusing on knowledge and awareness, suicide prevention approaches should focus on behaviour and skills. A combination of providing suicide intervention skills and lived experience stories about recovery empower communities to own and take control of the issue and as such is stigma reducing.

Lack of understanding of suicide and suicide intervention skills is a critical factor in poor care for people experiencing suicidal crisis. Lack of understanding and skills leads to stigmatising

behaviour towards individuals experiencing suicidality. This lack of understanding is reflected across the health care system from GPs, psychologists, and nurses. Currently suicide is only covered peripherally in the professional education system. Where it is covered, it is within a disciplinary paradigm often focused on assessment and risk management. Actual person-centred suicide intervention skills should be compulsory in the training of all mental health professionals as well as general health professionals likely to get in contact with people experiencing suicidality.

The overall object of the public stigma strategy is to build a social movement around a better understanding of mental health (and suicide). Public movements reflect power relations in the community they develop in. There is a risk that a public movement will cast mental health and suicide within the current dominant illness paradigm. When developing such movement, it is important that it is a lived experience led movement.

Priority 4: Reduce self-stigma.

Self-stigma is often a personal manifestation of public-stigma. Therefore, reducing public stigma will also reduce self-stigma. This is especially true amongst those bereaved by suicide where it can be difficult to separate out the person's self-stigma and that stigma applied publicly towards the bereaved person and the person lost. The strategy proposes measures to address self-stigma among people who support people, but separate measures targeting those with lived experience of suicide bereavement is also important.

The strategy highlights the importance of addressing self-stigma amongst lived experience workers. The section specifically included lived experience workers specialising in suicide and alcohol and other drugs. Peer workers may have self-stigma around their personal mental health experiences, impacted by general public stigma in society but also impacted by the institutional stigma expressed through the mental health system they work in.

Conclusion

The strategy is significant and will be an important contribution toward reducing stigma and discrimination against those experiencing mental ill-health including suicidality if implemented. It is a well-structured and logical overview of a complex area.

The strategy could benefit from greater clarity in its distinction and differentiation between a mental health crisis and the behaviour stemming from such crisis being suicidality. While this will add complexity to the document, it is required if the document is not to inadvertently become stigmatising towards those who experience suicidality.

The strategy highlights pre-conditions for reducing stigma and discrimination such as lack of adherence to current human rights and legislative requirements as well as the beneficial prospect of having rights enshrined in legislation and charters. The call for accountability needs to be imbedded in a restorative justice perspective to avoid the system going into "self-protection". In addition, the need for lived experience influence in decision making needs to clarify the diversity of lived experiences.

Structural stigma is underpinning both public and self-stigma and needs significant effort and attention. The document should acknowledge that a key to undermining structural stigma is to require the acknowledgement of trauma and damage caused by the system. The peer

workforce will have a key role in uncovering and supporting the acknowledgment of past trauma. Structural care needs to shift focus from risk and risk assessment towards collaborative person-centred care. Expansion of safe spaces of all types will be a significant move to overcome some of the structural stigma towards suicide and suicidality.

Reduction of public stigma requires public engagement. The strategy calls for the establishment of a social movement around mental health. It needs to be explained that a public movement around reduction of stigma for mental illness will be different to a social movement reducing stigma around suicide. A public campaign around suicide will be a combination of intervention skills (empowerment) and awareness which engages the population in the solution at a practical level. It is equally important that such approach is supported by the health care system and that front facing health care workers are trained in suicide intervention (not just suicide risk assessment).

The focus on self-stigma is key and is supported including self-stigma for the peer workforce. However, the strategy should also include measures for reducing of self-stigma around those bereaved by suicide acknowledging the complexity of this.

Acknowledgements Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Advice from individuals with lived experience helped guide the analysis and recommendations outlined in this policy position.

Feedback on the draft strategy was sought members of Suicide Prevention Australia's Lived Experience Panel prior to writing this document. The draft response was developed from a lived experience perspective before circulated to the Lived Experience Panel for comment.

As the national peak body for suicide prevention, our members are central to all that we do. This document was considered by the SPA Policy Committee prior to submission.