



National Survey of Mental Health-Related Stigma and Discrimination

November 2022

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Managing Director
Behavioural Economics Team of the Australian Government
Department of the Prime Minister and Cabinet
1 National Circuit
Barton ACT 2600
Email: beta@pmc.gov.au

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Research team

Behavioural Economics Team of the Australian Government:

Bradley Carron-Arthur, Bethany Jones, Jacqui Brewer, Laura Bennetts-Kneebone, Parima Vyas, Dana Leidl, Katrina Anderson, Ayndri De Soysa, Roxarne Armstrong and Simon Gordon.

National Mental Health Commission:

Michelle Blanchard, Emily Clay and Matthew Halpin.

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Who?

Who are we?

We are the Behavioural Economics Team of the Australian Government, or BETA.

We improve the lives of Australians by generating and applying evidence from the behavioural and social sciences to find solutions to complex policy problems

What do we do?

We apply our mix of specialist expertise and work collaboratively with partner agencies to:

- conduct research and provide advice on how people interact with programs and policy issues;
- design and test evidence-based solutions to complex policy problems;
- evaluate and measure the impact of programs and program changes;
- uplift APS capability to apply evidence from the behavioural and social sciences to public policy.

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About this report

In February 2021, the National Mental Health Commission (The Commission) approached the Behavioural Economics Team of the Australian Government (BETA) to help deliver a national survey of mental health-related stigma and discrimination.

Why?

The purpose of the survey was to support The Commission to develop and evaluate the National Stigma and Discrimination Reduction Strategy (The Strategy). Selected findings from the survey are included in The Strategy. The purpose of this report is to provide a full description of the survey methods and findings.

How?

The survey was completed in August 2021 by 7,873 Australians aged 18+ on a computer or by phone. In order to recruit a large high-quality sample representative of the Australian population, we used a mixture of probability and non-probability based sampling, with quotas for characteristics such as age, gender and location. We weighted the data to ABS census population benchmarks.

The survey questions were designed in collaboration with an advisory group comprising experts in mental health-related stigma with both lived and learned experience of mental ill-health. For full details of the method, see Appendix A.

What?

There were two modules within the survey. The first comprised questions regarding beliefs, intentions and behaviours in relation to people with personal lived experience of mental ill-health. This module was completed by all respondents.

A second module was completed by people who identified as having experienced a mental health problem in the prior 12 months. This second module asked questions about the respondent's personal experiences of mental health-related stigma and discrimination. A small group of people who reported experiencing mental health-related stigma and discrimination in the last 12 months despite their personal lived experience occurring more than 12 months ago were also asked to complete this module.

The main findings from this survey are described across three sections in this report that correspond to the structure of The Strategy (public stigma, structural stigma and self-stigma). The full set of questions and tables comprising item-level response-proportions are included in Supplementary Material to this report.

Note, all differences between sub-groups (such as demographic groups) included in this report are statistically significant at the conventional threshold ($p < .05$) unless stated otherwise.

Language matters

We acknowledge that individuals make sense of their experiences in different ways, that individuals have different preferences for how they would like their experiences described, and that not having these preferences respected can itself be stigmatising. We also recognise that language can have negative impacts and/or divide people in the way it is used and understood, particularly when it is used to stigmatise or label.

Consistent with the Strategy, we have tried to use terms in this report that are meaningful to a wide range of people. We acknowledge that the language used is ultimately imperfect to describe the inherently complex lived experience of stigma and discrimination.

Key terms used in this document

Common terms used throughout this document are defined in the glossary in Appendix B. In this document, each of these terms is used in the context of, or relating to, people with a lived or living experience of psychological distress, mental ill-health, trauma, suicidality and alcohol and other drug issues, and their families, friends, unpaid carers and support people.

To aid readability, throughout the report we have used the phrase “**people with personal lived experience**” to describe people with a lived or living experience of psychological distress, mental ill-health, trauma, suicidality and alcohol and other drug issues. To refer to specific instances of personal lived experience, we use the phrase “**mental health problem**”. We recognise that there is diversity in personal experiences of mental health and wellbeing, noting that mental health is experienced on a spectrum and across a lifetime, and definitions of mental health may be different for different people at different times.

We use the term “**support people**” to describe families, friends, unpaid carers and anyone whose primary relationship with the person concerned is a personal, supporting and caring one.

We recognise the diversity of ways that people and communities understand and conceive of mental health. In particular, we recognise that the term ‘mental health’ does not fully describe the experiences of many Aboriginal and Torres Strait Islander people. The term “**social and emotional wellbeing**” is used by many Aboriginal and Torres Strait Islander people to describe their social, emotional, spiritual, and cultural wellbeing. It acknowledges the importance of connection to community, family, land, sea, culture, and spirituality on their wellbeing.

Content warning

Due to the topic of this survey, this report contains frequent references to ideas that some people may find confronting.

Key findings

Based on our survey, we estimate over four million Australians experienced mental health-related stigma and discrimination in the prior 12 months. Most commonly, this came from people close to them. We found one in three people with recent personal lived experience reported unfair treatment by family and friends, and one in four reported unfair treatment by their spouse or partner. 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 of ten facing difficulties in finding a job.

Experiences of discrimination can have detrimental consequences. We 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.

Positive reactions from family and friends can have a buffering effect on self-stigma. For the one in six people whose families treated them a lot more positively in response to their mental health problem, there were more frequent reports of feeling satisfied with life and that having had a mental health problem had made them a stronger person. However, the opposite is also true. Over half the people who reported experiencing unfair treatment due to their mental health problem agreed with the statement, 'I feel like a burden to other people'.

We assessed the beliefs and intentions of the general population towards people with personal lived experience. We found the stigmatising beliefs and intentions they expressed were largely consistent with the experiences described by people with personal lived experience. Stigmatising beliefs and the desire to be socially distant from people with personal lived experience were disproportionately directed at people experiencing more complex mental health problems, such as schizophrenia. For example, two out of three people said they wouldn't be willing to work closely with someone with long-term schizophrenia. The rates for less stigmatised mental health problems were still high. For example, just over a quarter of people said they wouldn't want to work closely with someone with depression.

Experiences of stigma and discrimination were more common among females, younger people, and people who identify as LGBTIQ+. Expressing public stigma was also more common among young people, as well as males and people with a culturally and linguistically diverse (CALD) background.

Encouragingly, the majority of respondents did not express stigmatising beliefs and supported action to address mental health-related stigma and discrimination. Four out of five respondents agreed more needs to be done to eliminate discrimination towards people with personal lived experience.

Findings

Public stigma and experiences of discrimination

At the beginning of the survey, we asked all respondents to read two short vignettes. Each described a person experiencing symptoms of a mental health problem. Following this, we asked respondents whether they would be willing to engage socially with the person in a range of different activities (their intentions) and whether they agreed with various stigmatising statements about the person (their beliefs).

Box 1. The vignettes

There were eight different vignettes, each describing a different mental health problem:

Early schizophrenia	Depression	Non-suicidal self-injury	Bipolar disorder
Long-term schizophrenia	Social phobia	Borderline personality disorder	Eating disorder

Each respondent was shown and responded to questions relating to two vignettes. All respondents were shown the early schizophrenia vignette (below). The other was selected at random from among the seven other vignettes. See Supplementary Material for the text used in these vignettes.

“Please read the following statement about a person with a health problem. They are not a real person, but there are people who have had experiences like them. If you happen to know someone who resembles them in any way, that is just by chance.

The person is 24 years old. Since finishing school, they have had a few temporary jobs but they are currently unemployed. Over the last six months, they have stopped seeing friends and they have begun locking themselves in their bedroom. They often walk about their bedroom through the night. When alone, they sometimes shout and argue as if someone else is there. They are afraid to leave home because they think the neighbour is spying on them. They do not take recreational drugs.”

Intentions

Respondents

Australian residents aged 18+

100% of total sample

Across the different vignettes and activities, we observed a high degree of variability in people’s willingness to engage socially. Respondents showed the highest degree of reluctance to engage socially with a person experiencing long-term schizophrenia and the least regarding social phobia. As shown in Table 1, 62 percent of respondents reported being either ‘definitely not willing’ or ‘probably not willing’ to make friends with a person experiencing long-term schizophrenia. Whereas the same figure for social phobia was 14 percent.

Table 1. Proportion of respondents unwilling to engage in the activity with the person described in the vignette

Activity	Long-term Schizophrenia	Borderline Personality Disorder	Early Schizophrenia	Bipolar Disorder	Non-suicidal Self-injury	Depression	Eating Disorder	Social Phobia
Move next door to someone with this problem	64%	62%	55%	41%	39%	34%	26%	20%
Spend an evening socialising with someone with this problem	63%	55%	43%	37%	29%	25%	22%	15%
Make friends with someone with this problem	62%	59%	45%	40%	32%	25%	23%	14%
Work closely with someone with this problem	66%	61%	48%	47%	35%	29%	25%	18%
Have someone with this problem marry in to family	84%	82%	71%	63%	61%	52%	42%	29%
Have them look after your children	94%	91%	90%	81%	81%	77%	58%	40%

Note: Each proportion includes people who reported being 'definitely not' or 'probably not' willing. Item 'Have them look after your children' excludes people who responded 'Not applicable'.

Beliefs

Respondents

Australian residents aged 18+

100% of total sample

To understand what beliefs were associated with these discriminatory intentions, the survey followed up the question about social engagement with a series of statements comprising stigmatising beliefs and asked respondents to rate their level of agreement or disagreement with them. These statements were drawn from previous research on stigma (see Appendix for details). They assessed a range of stigmatising beliefs such as perceptions of dangerousness and perceptions of personal responsibility.

We found respondents were less likely to agree with statements characterising any of the mental health problems as a personal failing; for example, that it 'is their own fault' and it 'is not a real medical illness'. As shown in Table 2, these statements were endorsed by 4 to 14 percent of respondents.

Respondents were more likely to agree with statements that characterised any of the mental health problems as something out of a person's control; for example, that the person was 'unpredictable' and they 'feel pity' for the person. These statements were endorsed by 15 to 74 percent of respondents.

It was also common for respondents to agree with statements characterising people experiencing schizophrenia as 'dangerous' and that they should be 'forced into treatment' against their will.

Table 2. Proportion of respondents agreeing with each public stigma statement

Statement	Long-term Schizophrenia	Borderline Personality Disorder	Early Schizophrenia	Bipolar Disorder	Non-suicidal Self-injury	Depression	Eating Disorder	Social Phobia
It is their own fault that people with this problem are in this condition	4%	8%	5%	8%	6%	6%	11%	6%
This problem is not a real medical illness	6%	10%	7%	10%	7%	7%	11%	14%
People with this problem will never recover enough to have good quality of life	14%	10%	9%	7%	7%	5%	5%	7%
This problem is a sign of personal weakness	9%	14%	10%	9%	14%	9%	12%	13%
People with this problem could snap out of it if they wanted	10%	16%	10%	10%	11%	10%	16%	11%
People with this problem are dangerous	31%	44%	27%	19%	20%	8%	6%	6%
I feel scared of people with this problem	36%	40%	29%	18%	20%	7%	8%	6%
People with this problem should be forced into treatment with their doctor even if they don't want to	36%	30%	32%	21%	34%	19%	23%	11%
People with this problem are unpredictable	68%	74%	62%	67%	44%	29%	15%	16%
I feel pity for people with this problem	68%	57%	63%	49%	63%	59%	56%	52%

Note: Each proportion includes people who responded either 'strongly agree' or 'agree' to the statement in relation the mental health problem listed in the column.

Behaviour

Respondents

People who know someone with personal lived experience

80% of total sample

The above questions were about public stigma towards a hypothetical person. For the group of respondents who personally know someone with personal lived experience, we asked how they reacted towards that person. First, we asked all respondents to report whether they know someone in each of seven different relationship categories.

Of all respondents who completed the survey, 80 percent reported personally knowing at least one person with personal lived experience. As shown in Table 3, it was most common for people to report knowing a friend (60 percent). It was uncommon however to report only knowing a friend, with 95 percent of this group reporting they also knew someone in one of the other relationship categories. More than half of the entire sample (56 percent) reported knowing someone from at least three different relationship categories and 17 percent knew someone from at least six categories.

Table 3. Proportion of respondents reporting they know someone with personal lived experience, by relationship category

Relationship category	Yes
Friend	60%
Acquaintance	55%
Immediate family	49%
Extended family	49%
Colleague / employee	40%
Intimate partner	26%
Client / patient / student	22%

Of all the people who knew someone, 72 percent said at least one of these relationships was with a person who had experienced mental ill-health in the last 12 months. The survey asked them to think about their experience with one such person and to tell us about how they reacted to them.

As shown in Table 4, the majority reported positive intentions and behaviours. For example, 75 percent reported they had wanted to be understanding and to show support. However, fewer people reported going to the effort of spending more time with them than they normally would (31 percent). A minority group were not supportive. Twelve percent of respondents reported they felt sceptical about the person's mental health problem and 5 percent expressed this scepticism to the person.

Table 4. Proportion of respondents reporting how they reacted to a person they know with recent personal lived experience

Response	Yes
I wanted to be understanding and show my support	75%
I found ways to be supportive (e.g. listened to them)	72%
I spent more time with them than I normally would	31%
I felt sceptical about their mental health problem	12%
I expressed scepticism about their mental health problem to them	5%
I spent less time with them than I normally would	7%
I avoided them altogether	3%

Note: Column sums to greater than 100 percent because respondents were asked to select all that apply.

People with personal lived experience

Respondents

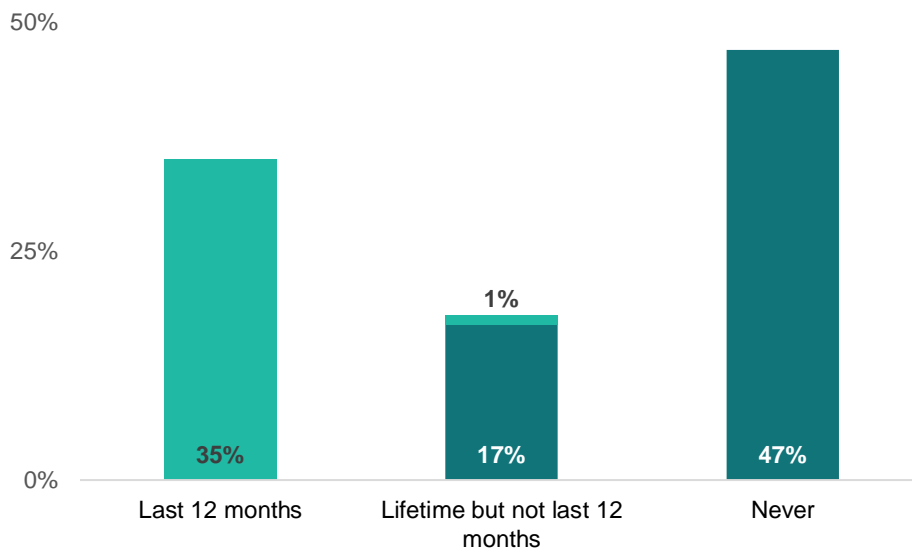
People with personal lived experience

53% of total sample

In order to assess public stigma from the perspective of the person affected by discriminatory behaviour, we asked respondents to identify whether they had personally experienced a mental health problem (see the Glossary regarding how this was defined in the survey for respondents).

Of the 7,873 adults who completed the survey, 35 percent reported experiencing a mental health problem in the last 12 months. A further 18 percent reported having experienced a mental health problem at some point in their life but not in the last 12 months. We asked this group if they had had ongoing experiences of stigma and discrimination in the last 12 months despite their mental health problem occurring more than 12 months ago. A small group (1 percent of the total sample) reported this was the case.

As shown in Figure 1, we then only asked subsequent questions of people who reported experiencing a mental health problem in the last 12 months (35 percent) and the small group with ongoing experiences of stigma and discrimination (1 percent). The following sections pertain to this combined group (36 percent of the total population), who are referred to hereafter as people with recent personal lived experience. We also note all references to experiences of stigma and or discrimination have the past 12 months as their timeframe.

Figure 1. Proportion of all respondents reporting personal lived experience

Note: only the groups marked with light shading were shown subsequent questions about mental health-related stigma and discrimination.

Experiences of discrimination in private life domains

Respondents

Participants with recent personal lived experience

36% of total sample

We asked respondents whether they had been treated unfairly because of their mental health problem. We asked them to report their experiences in 12 different life domains and, as shown in Box 2, only to report events that happened during the last 12 months. Sixty three percent reported experiencing at least one instance of unfair treatment. Given there are approximately 20 million* adult residents in Australia, this equates to approximately 4.5 million people, who in their experience, have been discriminated against at some point in the prior 12 months because of their personal lived experience.

Box 2. 'Unfair treatment'

To be clear what we meant by 'unfair treatment', we supplied the following text in the survey:

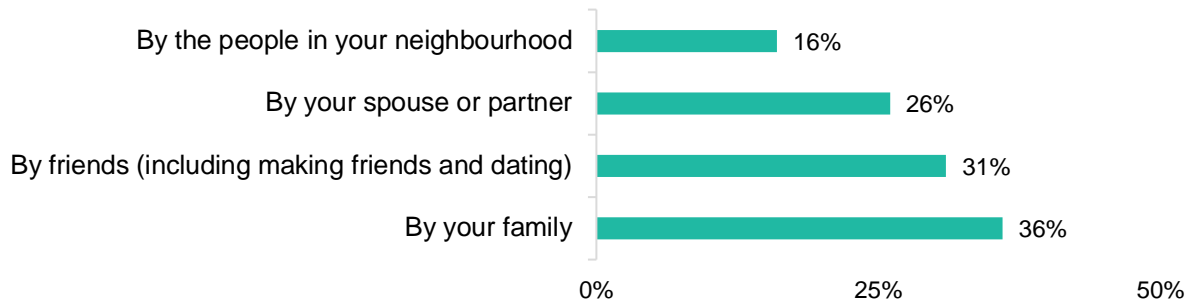
*"In this section, we ask about times when you have **been treated unfairly because of the mental health problems you have experienced.***

*For each question, please only report events that have **happened during the last 12 months.**"*

* The Australian Bureau of Statistics estimates 20,068,063 Australian are aged 18+ as of Sep 2021 (ABS, 2021)

We found it was most common for respondents to report experiences of unfair treatment by their family (36 percent) followed by friends (31 percent) and spouse (26 percent). As shown in Figure 2, it was less common for respondents to report unfair treatment by people in their neighbourhood (16 percent).

Figure 2. Proportion of people with recent personal lived experience reporting unfair treatment by family, friends, partner and people in neighbourhood



To understand more about these issues, we followed up with a question about what had happened. We asked respondents to report on how they perceive they were treated unfairly. In each of the above life domains, the most common response selected was about not being shown sympathy or understanding. This was endorsed by 64 percent of people who reported being treated unfairly by family, 62 percent of people who reported being treated unfairly by their spouse, and 57 percent of people who reported being treated unfairly by friends.

In each of these three life domains (family, spouse and friends), more than half of the respondents also reported people being dismissive of the problem; and just over half (51 percent) reported friends avoided or cut contact with them.

Table 5. Nature of reported unfair treatment by family, friends and partner

Nature of unfair treatment	By family	By friends	By partner
They were not understanding and sympathetic	64%	57%	62%
They were dismissive of the problem	56%	51%	54%
They avoided or cut contact with me	26%	51%	18%
They were judgemental	50%	49%	40%
They were insulting towards me	27%	21%	33%
They got angry at me	28%	20%	34%
Other	1%	1%	3%
Don't know / Prefer not to say	1%	1%	3%

Note: Columns sum to greater than 100 percent because respondents were asked to select all that apply.

We also asked respondents whether people had treated them more positively than they normally do in response to their recent personal lived experience (See Box 3 regarding how this was framed in the survey). Just over half indicated their family or friends had treated them more positively.

Box 3. 'More positively'

To be clear what we meant by 'more positively', we supplied the following text in the survey:

"Being treated "more positively" is relative to how you were treated by a person before they were aware of your mental health problem or compared to how they treat people who don't have a mental health problem"

As shown in Table 6, this can be further broken down into those who said it was 'a little bit', 'moderately' or 'a lot' more positive. Around one in four reported 'not at all', and one in five reported the question was 'not applicable' to them.

Table 6. Proportion of people with recent personal lived experience reporting the extent to which they were treated 'more positively' by family and friends

Domain	A lot	Moderately	A little	Not at all	NA
Treated more positively by family, including your spouse / partner	17%	17%	23%	26%	17%
Treated more positively by friends	13%	17%	23%	26%	22%

Support person experiences of stigma and discrimination

Respondents

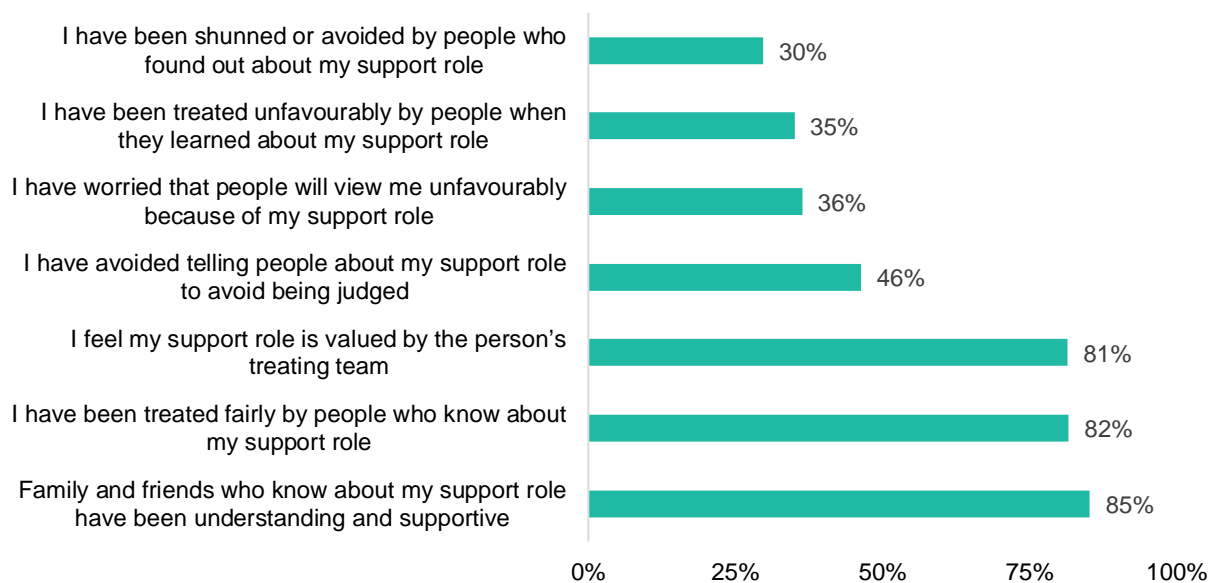
Support persons

40% of total sample

Stigma and discrimination is often thought of in relation to a person with personal lived experience. However, as shown in Figure 3, family, friends and unpaid carers who perform an important support role can also be subject to stigma and discrimination by association. To assess these people's experiences of associated stigma, we first asked respondents whether they identified as a support person for someone with personal lived experience. See the Glossary in Appendix B regarding how 'support person' was defined in the survey for respondents.

Forty percent of all survey respondents identified as being a support person. Of these, the majority reported positive experiences. For example, 85 percent reported feeling supported by family and friends. However, a sizeable minority also reported negative experiences. Thirty percent reported being shunned or avoided by people who found out about their support role.

Figure 3. Proportion of support persons reporting discriminatory experiences



Differences in expression of public stigma by demographic group

The survey included a range of demographic questions. These questions allowed us to identify whether there were some demographic groups who were more or less likely to express public stigma. We found males, younger people and people from culturally and linguistically diverse (CALD) backgrounds were more likely to express public stigma than other groups.

Respondents by gender

Male

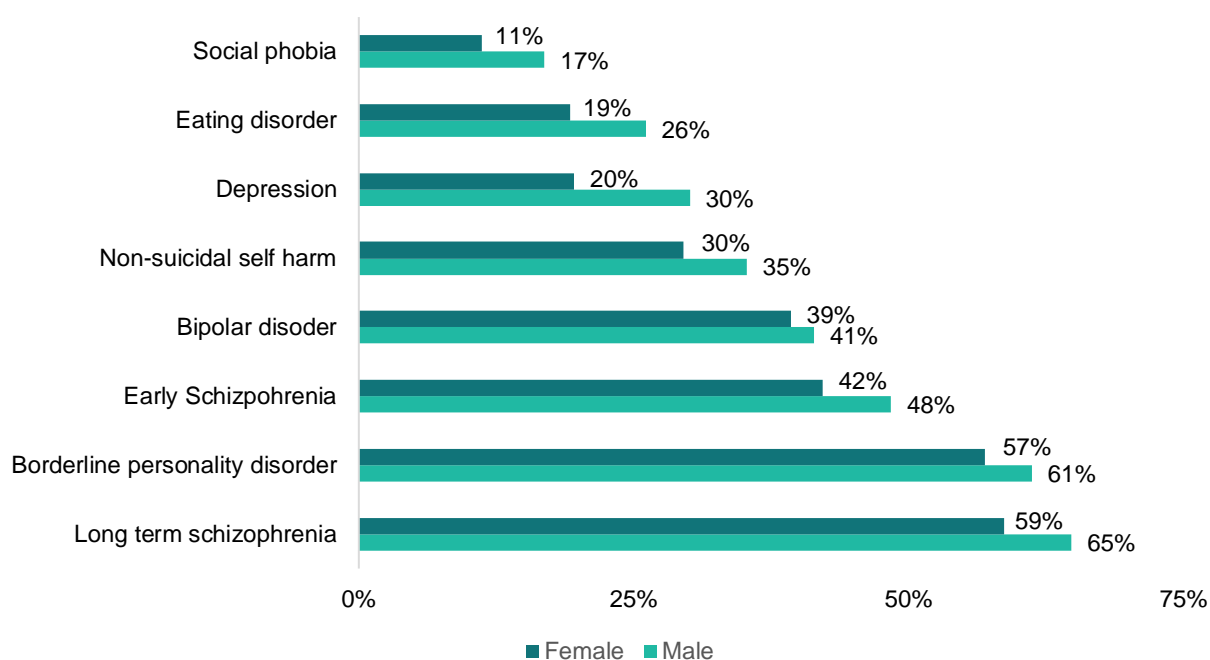
49% of total sample

Female

51% of total sample

Men were consistently more likely to report being unwilling to engage socially with a person experiencing a mental health problem across all eight mental health problems we assessed. As shown in Figure 4, this ranged between being a two percentage point difference for bipolar disorder* and a ten percentage point difference for depression.

Figure 4. Proportion of males and females who were unwilling to make friends with a person experiencing a mental health problem, by type of mental health problem.



* Note, this 2 percentage point difference for bipolar disorder was marginally significant ($p=.1$). The remainder were all statistically significant at conventional threshold ($p<.05$).

Respondents by age

18-24	12% of total sample	45-64	31% of total sample
25-44	36% of total sample	65+	21% of total sample

Younger people were more likely to endorse the statements that contained stigmatising beliefs. As shown in Figure 5, people between the ages of 18-44 were more than twice as likely to agree with the statement ‘This problem is a sign of personal weakness’ in relation to early schizophrenia.

Respondents by CALD status

CALD	27% of total sample
Not CALD	73% of total sample

Similarly, people identifying as being from a culturally and linguistically diverse (CALD) background were more likely to endorse the statements that contained stigmatising beliefs. As shown in Figure 6, people with a CALD background were more than three times as likely to agree with the statement ‘This problem is a sign of personal weakness’ in relation to early schizophrenia.

Figure 5. Proportion of people agreeing with the statement ‘This problem is a sign of personal weakness’, by age category.

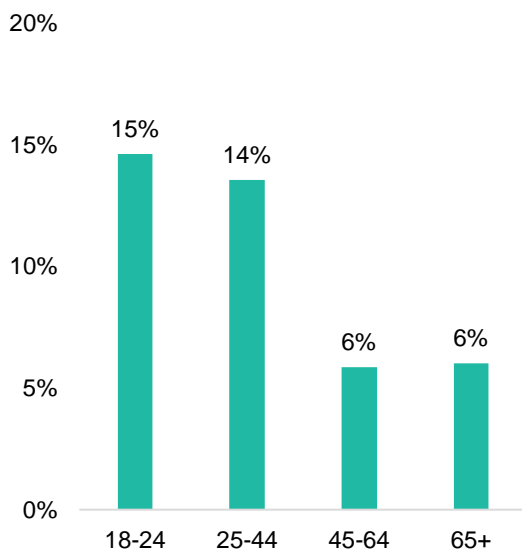
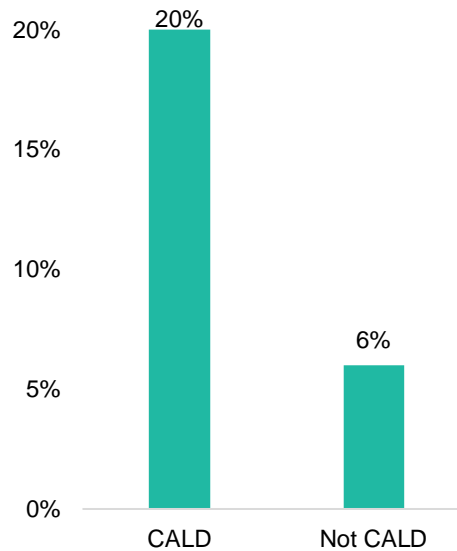


Figure 6. Proportion of people agreeing with the statement ‘This problem is a sign of personal weakness’, by CALD status.



Differences in experience of public stigma by demographic group

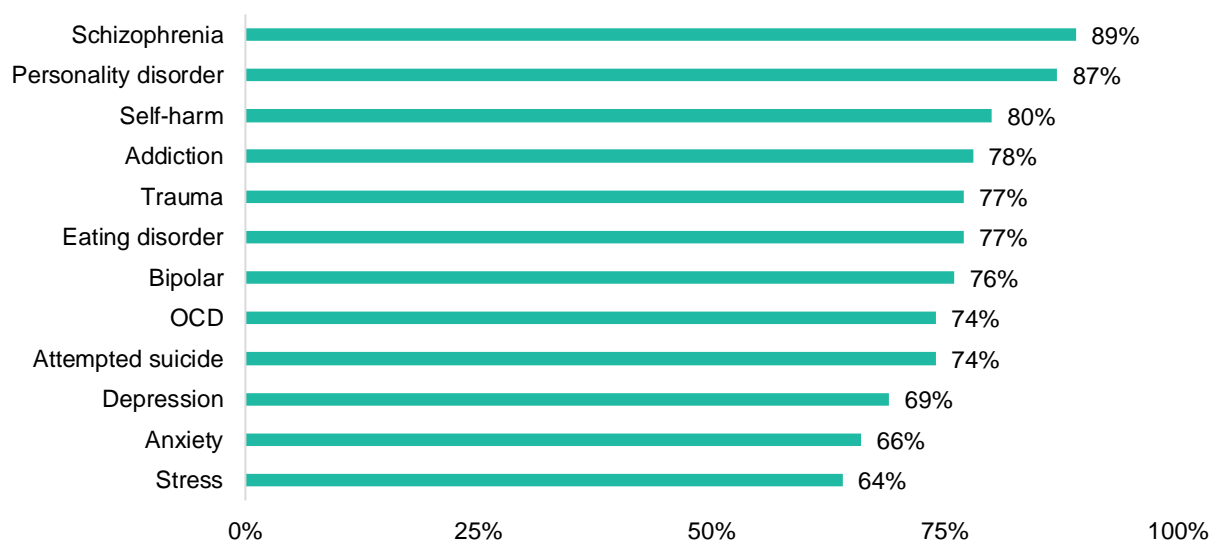
Respondents

Participants with recent personal lived experience

36% of total sample

When respondents told us they had experienced a mental health problem, we followed up with a question about the nature of their experience. From this, we were able to identify whether people with some mental health problems experience unfair treatment more often than others. As shown in Figure 7, we found that people with experiences of schizophrenia, schizoaffective disorder or psychosis (4 percent of those with recent personal lived experience), were among the most affected with 89 percent reporting being treated unfairly in at least one life domain.

Figure 7. Proportion of people with recent personal lived experience reporting experience of unfair treatment, by type of mental health problem.



Note: **Stress** comprises responses 'Emotional distress', 'Stress' and 'Burnout' (66% of people with recent personal lived experience); **Anxiety** comprises 'Anxiety', 'Anxiety disorder', 'Agoraphobia', 'Panic disorder' (73%); **Depression** comprises 'Depression', 'Major depression (71%)'; **Attempted suicide** comprises 'Attempted suicide', 'Thought about attempting suicide' (31%); **OCD** comprises 'Obsessive-compulsive disorder', 'OCD' (11%); **Bipolar** comprises 'Bipolar', 'Bipolar disorder', 'Manic-depressive disorder' (6%); **Eating disorder** comprises 'Eating disorder', 'Anorexia', 'Bulimia', 'Binge eating disorder' (11%); **Trauma** comprises 'Post-traumatic stress disorder', 'PTSD', 'Complex trauma' (26%); **Addiction** comprises 'Alcohol problem', 'Alcoholism', 'Drug problem', 'Drug addiction', 'Gambling problem', 'Gambling harm' (13%); **Self-harm** comprises 'Self-harm' (13%); **Personality disorder** comprises 'Personality disorder', 'Borderline personality disorder' (6%); **Schizophrenia** comprises 'Schizophrenia', 'Paranoid schizophrenia', 'Schizoaffective disorder', 'Psychosis', 'Psychotic disorder' (4%). Respondents were able to select as many mental health problems as were applicable to them.

Some demographic groups reported experiencing mental health-related stigma more frequently than others. This included females, younger people and people who identify as LGBTIQ+*. For females, this was partly because women reported experiencing mental ill-health more frequently than men (and experiencing mental health-related stigma is dependent on experiencing mental ill-health). Twenty seven percent of all women reported experiencing unfair treatment in relation to a mental health problem, compared with 19 percent of all men. When we compared only among those with recent personal lived experience, there wasn't a significant difference between females (65 percent) and males (62 percent) reporting experiences of unfair treatment ($p=.2$).

For younger people and people who identify as LGBTIQ+, there was similarly an elevated rate of mental health-related stigma due to these groups experiencing higher rates of mental ill-health. However, there was also a difference among the sub-group that included only those with recent personal lived experience. Seventy two percent of LGBTIQ+ respondents reported any kind of unfair treatment in relation to their mental health problem, compared with 62 percent of others (as shown in Figure 8). Seventy nine percent of people aged 18-24 reported experiencing unfair treatment, compared with 66 percent, 60 percent and 44 percent among people aged 25-44, 45-64 and 65+ respectively (as shown in Figure 9).

Figure 8. Proportion of people with recent personal lived experience reporting experiences of unfair treatment, by LGBTIQ+ status.

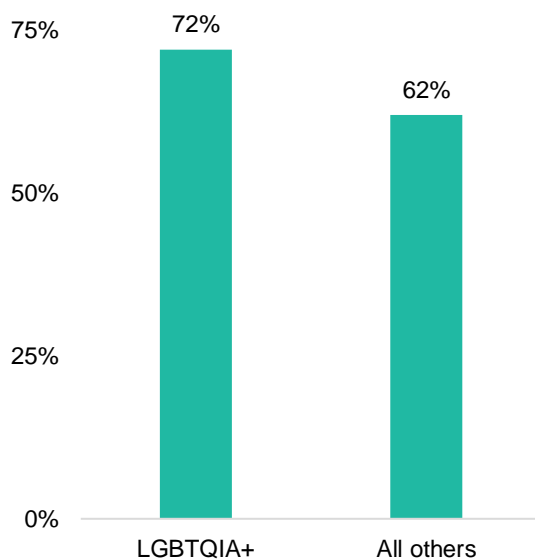
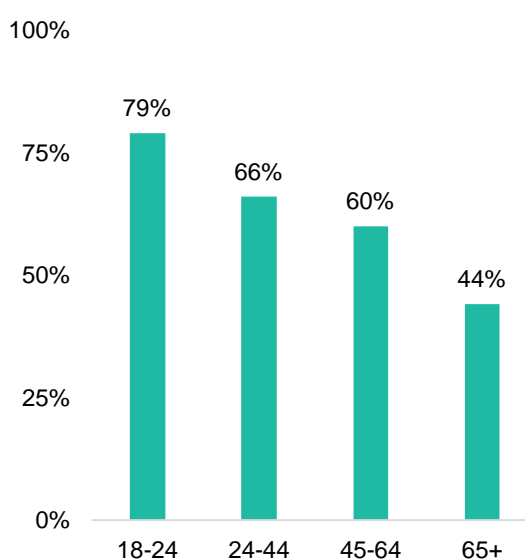


Figure 9. Proportion of people with recent personal lived experience reporting experiences of unfair treatment, by age group.



Note: Respondents who identified as LGBTIQ+ comprised 7 percent of the total sample.

* LGBTIQ+ participants were identified by their responses to two items. If they reported their gender as other than 'male' or 'female', or if they reported their sexual orientation as anything other than 'straight (heterosexual)'.

Structural stigma and experiences of discrimination

Structural stigma beliefs

To understand how people view issues regarding structural stigma, we presented eleven statements to all respondents and asked them about their level of agreement or disagreement. For some statements, agreement with the statement could suggest the respondent holds a stigmatising belief. For others, disagreement with the statement could suggest the respondent holds a stigmatising belief (these are labelled as 'reverse' in Figure 10).

Respondents

Australian residents aged 18+

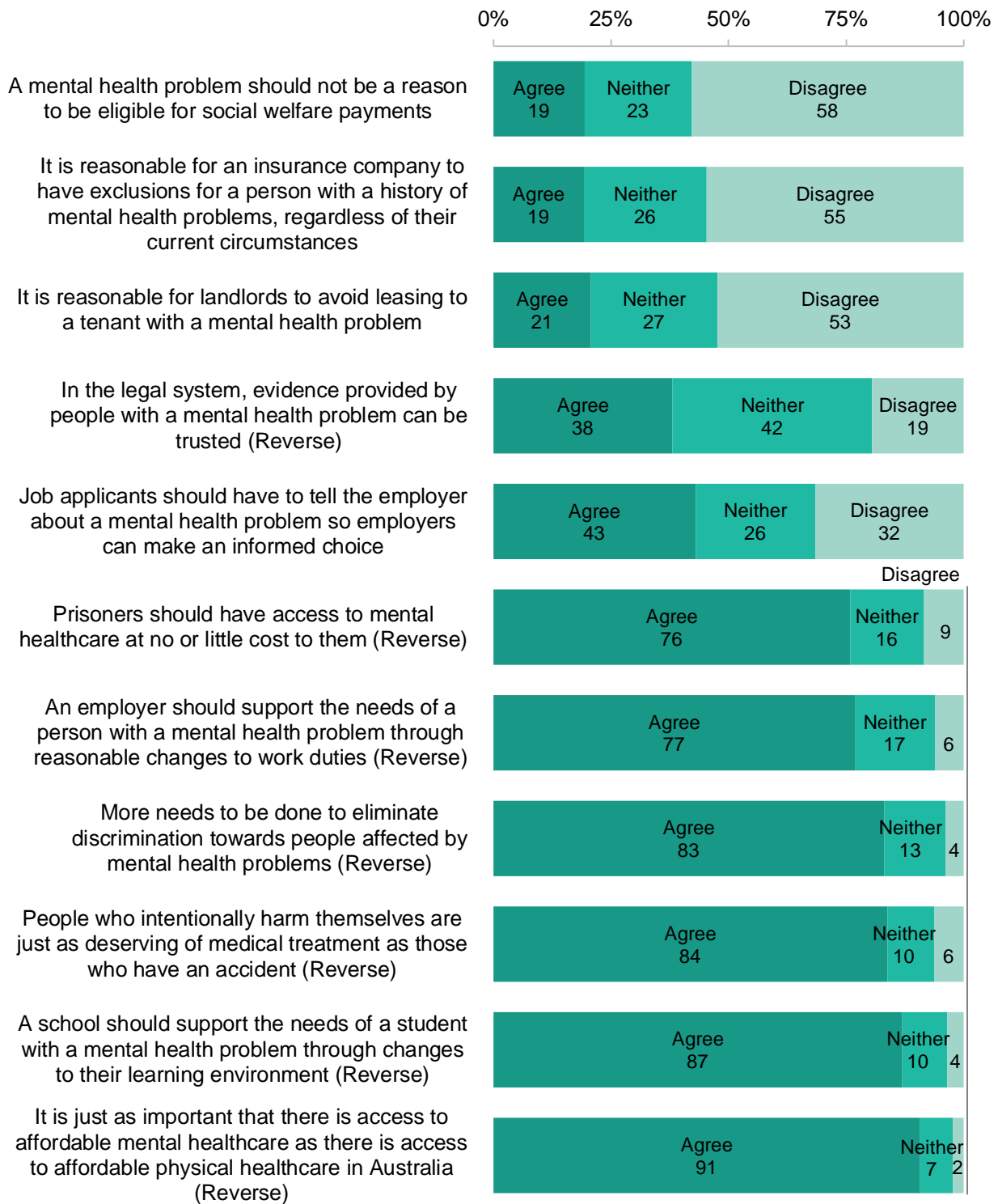
100% of total sample

On most of the issues, the majority of the sample responded in a way that suggests they do not hold stigmatising beliefs in relation to the issue. For example, 83 percent of respondents agreed more needs to be done to eliminate discrimination towards people affected by mental health problems.

There were two issues for which there was a different pattern of responses.

- Forty three percent of respondents agreed with the statement 'Job applicants should have to tell the employer about a mental health problem so employers can make an informed choice'. A further 26 percent would neither agree nor disagree with this and only 32 percent disagreed with it. This means that the majority of the population is not opposed to the idea of mandatory disclosure.
- Forty two percent of respondents would neither agree nor disagree with the statement 'In the legal system, evidence provided by people with a mental health problem can be trusted'. A further 19 percent disagreed with the statement and only 39 percent agreed with it. This means that the majority of the population has hesitations about the trustworthiness of evidence provided by people with a mental health problem in the legal system.

Figure 10. Agreement and disagreement with each structural stigma statement.



Experiences of discrimination in public life domains

Respondents

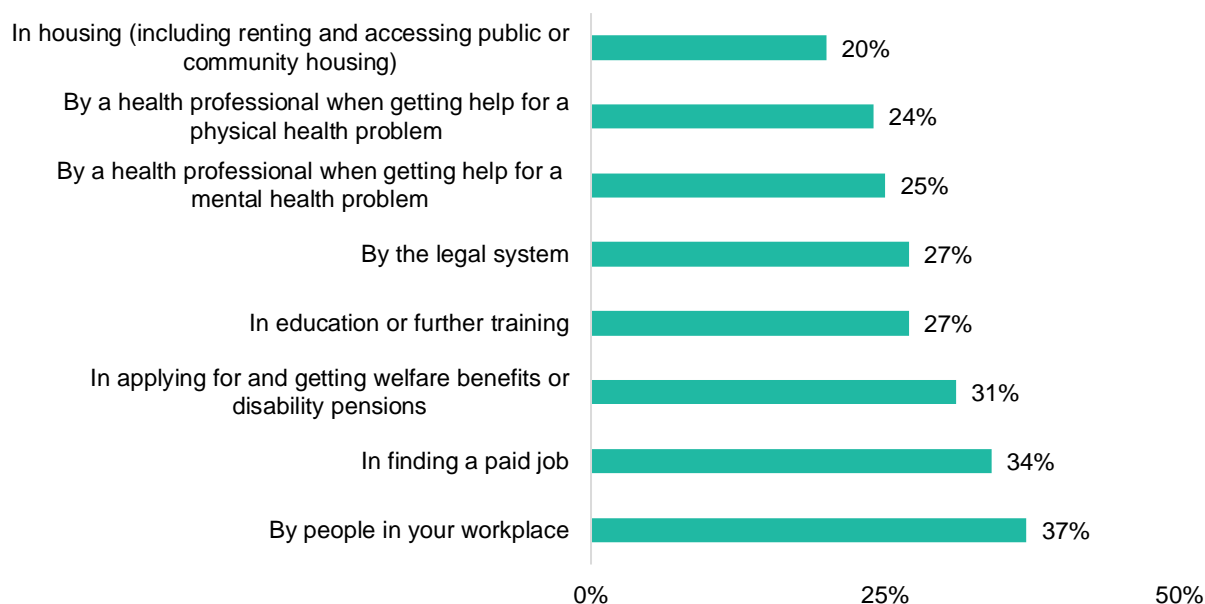
Participants with recent personal lived experience

36% of total sample

Previously, we described measuring experiences of unfair treatment in four life domains (family, friends, partner and neighbourhood). We also asked respondents with recent personal lived experience to report unfair treatment in eight more public life domains (housing, legal system, welfare, education and training, physical healthcare, mental healthcare, workplace and in finding a paid job). In general, experiences of unfair treatment were less common in these eight life domains than the previous four life domains. This is partially because some of these public life domains, such as the welfare system, are not applicable to the entire population.

When we accounted for this (by excluding those who say the life domain is not applicable to them) we found the proportion of people reporting unfair treatment is high. As shown in Figure 11, it was 37 percent among those in the workplace, 34 percent for those who were looking for paid employment and 31 percent for those who were applying and or receiving welfare benefits. Seeking paid work was particularly problematic for people experiencing schizophrenia, with 79 percent of this group reporting some degree of unfair treatment in this life domain.

Figure 11. Proportion of people with recent personal lived experience reporting experience of unfair treatment in public life domains (excluding those who reported NA for the life domain).



Twenty five percent of respondents reported experiencing unfair treatment by a health professional when getting help for a mental health problem. We then asked what type of health professional this was and respondents were able to select as many as was relevant.

As shown in Table 7, the most common professions identified were GPs (by 63 percent of respondents), psychologists (35 percent) and counsellors / psychotherapists (23 percent).

We also asked about the nature of the unfair treatment. As shown in Table 8, frequently endorsed responses were about health professionals being dismissive or sceptical (53 percent), judgemental (50 percent), not being willing to listen (46 percent) and not being supportive (47 percent). However, there were also high reports of health professionals lacking an understanding of their mental health problem (51 percent), ignoring physical health problems (32 percent) and prescribing medication without adequate explanation, information, consultation or attempt to discuss alternatives (31 percent).

Table 7. Type of health professional reported to have treated respondent unfairly.

Profession	Proportion
GP	63%
Psychologist	35%
Counsellor / psychotherapist	23%
Psychiatrist	21%
Nurse	16%
Emergency department doctor	14%
Social Worker	11%
Mental Health Peer Worker	9%
Ambulance staff	8%
Care Coordinator	6%
Occupational Therapist	5%
Complementary therapist/ traditional healer	3%
Patient advocate	2%
Other	2%
Don't know / Prefer not to say	3%

Note: Column sums to greater than 100 percent because respondents were asked to select all that apply.

Table 8. Nature of reported unfair treatment by health professional when getting help for a mental health problem.

Nature of unfair treatment	Proportion
They were dismissive or sceptical	53%
They lacked an understanding of my condition	51%
They were judgemental	50%
They were not supportive or caring	47%
They were not willing to listen	46%
They ignored my physical health problems	32%
They prescribed medication without adequate explanation, information, consultation or attempt to discuss alternatives	31%
There was a delay or problem in helping me access care	23%
They tried to avoid dealing with me	20%
They refused to prescribe medication	14%
Other	1%
Don't know / Prefer not to say	2%

Note: Column sums to greater than 100 percent because respondents were asked to select all that apply.

Stigma and discrimination in the workplace

People who reported unfair treatment in the workplace were also asked what happened. Forty three percent reported they were treated as if they were incompetent, 34 percent reported they had been denied opportunities and 17 percent that they had been fired or made redundant because of their mental health problem; 43 percent reported people in their workplace weren't supportive of their needs and 22 percent reported they were forced to change responsibilities. Similar to the other life domains, there were issues in how people experienced relationships with others, with 45 percent of people reporting others were dismissive of their problem and 32 percent reporting they were avoided or excluded.

Table 9. Nature of reported unfair treatment by people in their workplace

Nature of unfair treatment	Proportion
They were dismissive of the problem	45%
They treated me as if I was incompetent	43%
They weren't supportive of my needs	43%
I was denied opportunities	34%
They avoided or excluded me	32%
I was forced to change responsibilities	22%
I was fired or made redundant	17%
Other	3%
Don't know / Prefer not to say	3%

Note: Column sums to greater than 100 percent because respondents were asked to select all that apply.

Respondents

People who have done paid or voluntary work in the last 12 months

51% of total sample

We separated working respondents into two groups: those who held a managerial or supervisory role and those who did not. To each of these groups we posed a series of statements and asked the extent to which they agree or disagree with them.

We found 50 percent of managers agreed with the statement 'Potential employees should disclose mental health problems prior to recruitment' and that 43 percent of managers felt organisations take a significant risk when employing people with mental health problems in a public or client-facing role. Seventeen percent of managers said they would not want to employ or supervise someone who had been treated for a mental health problem.

Similarly, 17 percent of non-managerial workers said they would not want to be supervised by someone who had been treated for a mental health problem. Fourteen percent felt that 'you can't rely on an employee with a mental health problem'.

There was also strong support for assistance with 84 percent of managers agreeing Australian workplaces need more support to improve the way workplaces deal with mental health problems and 73 percent of employees reporting workplaces lose talent due to a lack of understanding of how to address mental health in the workplace.

We compared responses across the different industries in which respondents were employed and did not observe any clear differences in stigma and discrimination between them.

Self-stigma and anticipation of discrimination

Self-stigma

To measure self-stigma, the survey asked respondents who had recent personal lived experience to rate their agreement with a series of statements (as shown in Figure 12).

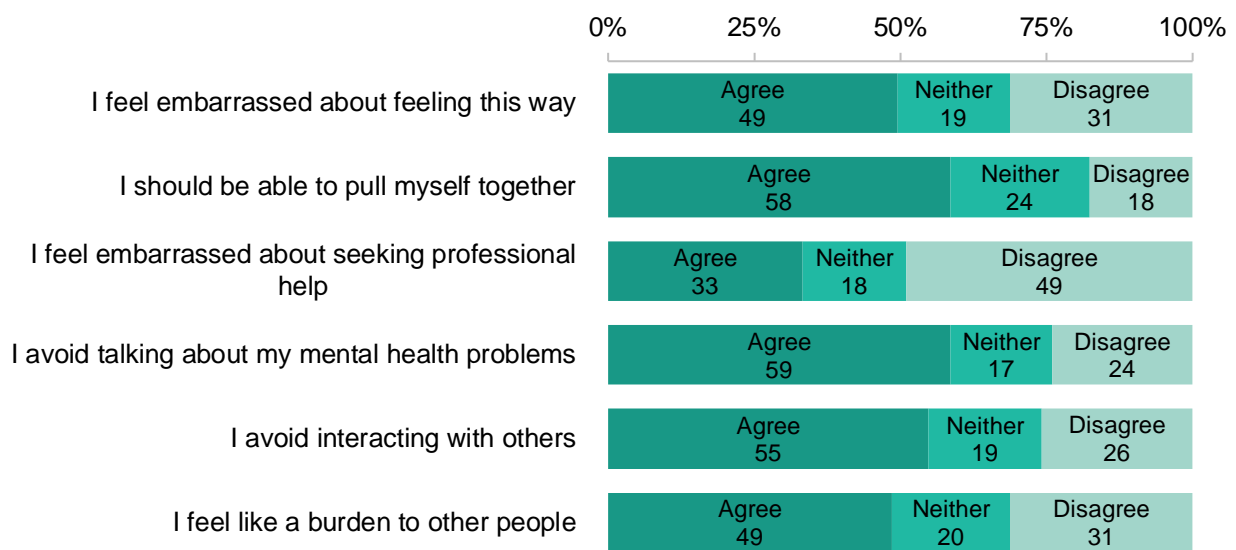
Respondents

Participants with recent personal lived experience

36% of total sample

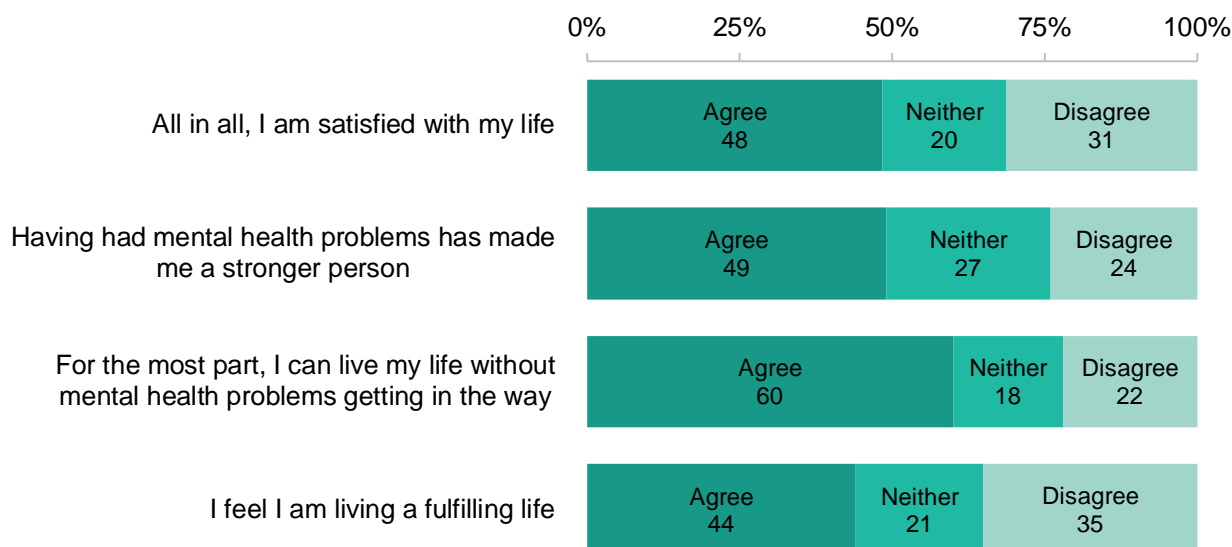
Around half of the respondents endorsed these statements. For example, 58 percent agreed with the statement ‘I should be able to pull myself together’.

Figure 12. Proportion of people with recent personal lived experience agreeing with self-stigma statements.



The survey also asked respondents to rate their agreement with four positively-framed or self-affirming statements (as shown in Figure 13). Again, around half of the respondents agreed with each of these statements. For example, 49 percent agreed with the statement 'Having had mental health problems has made me a stronger person'.

Figure 13. Proportion of people with recent personal lived experience agreeing with each positive statement.



Self-stigma and its self-affirming counterpart were found to be associated with the way people have been treated.

Among respondents who have experienced unfair treatment, we found more-frequent reports of:

- Feeling like a burden to other people (57 percent compared with 34 percent of others);
- Avoiding interacting with others (62 percent compared with 42 percent of others);
- Avoiding talking about the mental health problem (63 percent compared with 51 percent of others);
- Being embarrassed about feeling this way (57 percent compared with 37 percent of others) ; and
- Feeling embarrassed about seeking professional help (38 percent compared with 25 percent of others).

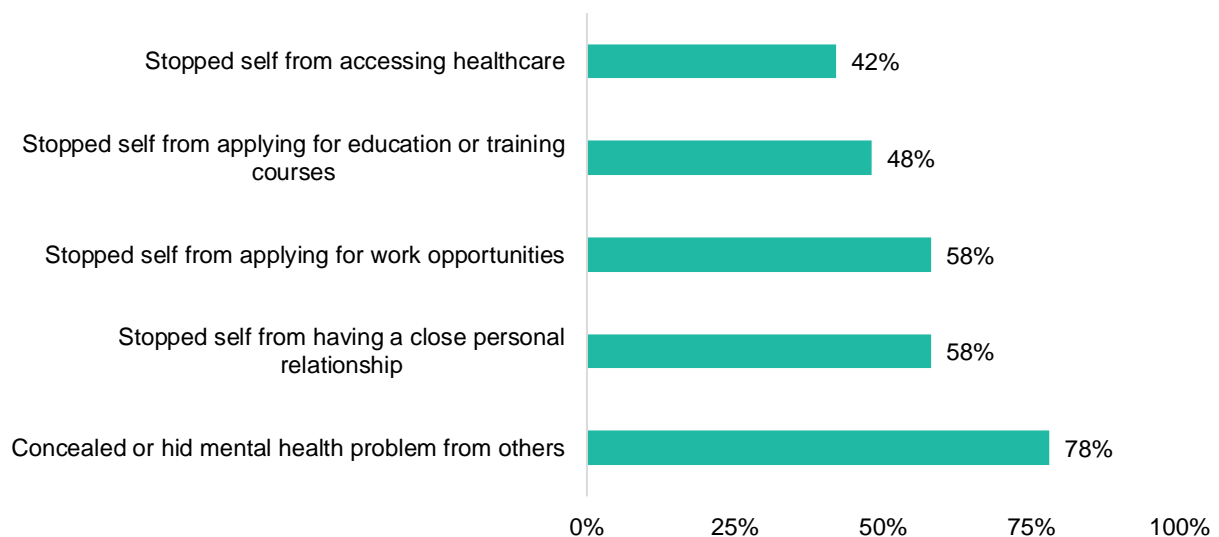
Among those who have been treated 'a lot' more positively by family, we found more-frequent reports of:

- Satisfaction with life (63 percent compared with 45 percent of others);
- Feeling that having had a mental health problem has made them a stronger person (61 percent compared with 47 percent of others);
- Feeling that for the most part they can live their life without mental health problems getting in the way (68 percent compared with 59 percent of others); and
- Feeling that they are living a fulfilling life (59 percent compared with 41 percent of others).

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. To assess the extent to which this anticipation of stigma affects people, we asked respondents to report times in the last 12 months when they have stopped themselves from doing things that are important to them because of how others might respond to their mental health problem. We found 78 percent reported 'concealing or hiding their mental health problem from others'. As shown in Figure 14, this was the most common way in which stigma was anticipated and avoided. We also found 42 percent reported having stopped themselves from accessing healthcare.

Figure 14. Proportion of people with recent personal lived experience who have avoided something in anticipation of stigma.



People who had been treated unfairly in a particular domain were also more likely to avoid these domains in future. People who reported having experienced unfair treatment by a health professional when seeking help for either their physical or mental health were more than twice as likely to report having stopped themselves from accessing health care in the past 12 months than someone who has not reported experiencing unfair treatment (67 percent versus 30 percent).

The rate of people stopping themselves from applying for employment opportunities was almost three times greater among people who reported being treated unfairly in finding a paid job than those who didn't (78 percent versus 27 percent); and more than two times greater among those who had reported being treated unfairly in the workplace than those who hadn't (65 percent vs 29 percent). There was a similar trend for education and training (69 percent versus 21 percent).

Regarding interpersonal relationships, respondents who had experienced unfair treatment by their family were almost twice as likely to report stopping themselves from having a close personal relationship (66 percent versus 37 percent).

Respondents who had experienced unfair treatment by a friend were more likely to report concealing or hiding their mental health problem from others (89 percent versus 67 percent).

This shows stigma and discrimination don't only have an immediate negative impact on a person. Stigma and discrimination has future implications that can have lasting detrimental repercussions.

Appendix A: Method detail

Administration of the survey and recruitment of participants was undertaken by The Social Research Centre and affiliate partner I-Link. Participants completed the survey between the 10th and 30th of August 2021. The average length of the survey was 24.2 minutes for participants who completed both the general survey and the module for people with recent personal lived experience, and 15.4 minutes for those who completed only the general survey. Participants who completed the longer version of the survey received \$15 for participation. Participants of the shorter version received \$10.

Mode

The majority of participants (n=7,723) completed the survey online. A small minority of participants (n=150) opted to complete the survey over the phone by Computer-Assisted Telephone Interview (CATI). There was a minor difference between the survey completed by online and CATI respondents. CATI respondents were only asked questions in relation to one vignette – the early schizophrenia vignette. They were also not asked about their agreement with the stigmatising statements in relation to this vignette. This is because these questions are long and it is difficult to answer over the phone. We decided on balance it was better to minimise burden to CATI participants than collect this data.

Recruitment

Participants were sourced from two online panels: the Social Research Centre's Life in Australia™ panel and I-Link's online panel. Of the 7,873 total participants, 3,495 came from the Life in Australia panel and 4,378 came from I-Link's panel.

Life in Australia™ panel: Comprises a probability-based sample of Australians aged 18+ recruited via random-digit dialling for the purpose of social research.

I-Link panel: Comprises a non-probability-based sample of Australians aged 18+ who opt in to the panel for the purpose of participating in market and social research.

Weights

Unless otherwise stated, data in this report and the Supplementary Material is weighted to population benchmarks. The calculation of sample weights was performed by the Social Research Centre and consisted of the following steps:

1. Compute a base weight for each Life in Australia respondent as the product of two weights:
 - a. Their enrolment weight, accounting for the initial chances of selection and subsequent post-stratification to key demographic benchmarks.
 - b. Their response propensity weight, estimated from enrolment information available for both respondents and non-respondents to the present wave.
2. Adjust the base weights so they satisfy the latest population benchmarks for several demographic characteristics.

3. Compute a combined weight for the blended dataset (both Life in Australia and I-Link) following the 'superpopulation' approach using outcome data from the survey in addition to demographic data with population benchmarks.

Ethics and Privacy

The ethical aspects of this research have been approved by the Macquarie University Human Research Ethics Committee (2021/10407). Data collection and storage complies with Australian Privacy Principles.

Survey design

We designed the survey with input from the National Stigma and Discrimination Reduction Strategy Measurement Technical Advisory Group (see 'Acknowledgements' on page 1 for membership). This group comprised people with both lived and learned experience of mental ill-health. We drew on the wealth of literature and existing instruments designed to measure mental health-related stigma. We acknowledge the following as sources for questions adapted into our survey:

- The Social Distance Scale (Link et al., 1999).
- The Personal Stigma Subscale of the Depression Stigma Scale (Griffiths, Christensen & Jorm, 2008).
- The Attribution Questionnaire (Cooper, Corrigan, & Watson, 2003).
- Our Turn to Speak Survey (Groot et al. 2020).
- Self-stigma of Seeking Psychological Help Scale (Vogel, Wade & Haake, 2006).
- Carer experiences of stigma scale (Griffiths, 2014).
- Opening minds survey for workplace attitudes (Pietrus, 2013).
- National Survey of Discrimination and Positive Treatment (Reavley, 2015) including studies which codified the most frequently reported experiences of discrimination by friends and family (Morgan 2017), by colleagues in the workplace (Reavley 2016) and by healthcare professionals (Morgan 2016).
- 'Answering the Call' National Survey (BeyondBue, 2018).
- The Mental Illness Stigma Scale (King et al., 2007).

The following vignettes used in this study were adapted from the following sources:

- Depression, Early Schizophrenia, Long-term Schizophrenia, Social Phobia (Reavley, 2015).
- Bipolar Disorder (Elison, Mason & Scior, 2015).
- Borderline Personality Disorder (Sowislo et al., 2017).

To standardise the approach across all vignettes, we did not use a name or gender to describe the person. We presented symptoms consistent with DSM diagnostic criteria and removed extraneous details about their life.

Appendix B: Glossary

Stigma – The disapproval of, or discrimination against, an individual or group based on characteristics that serve to distinguish them from other members of a society. Stigma results from complex social, political and psychological processes and can include negatively stereotyped characteristics, attitudes and responses that are community socialised and/or structural which harm a person's day-to-day health and wellbeing by excluding, devaluing or shaming them (Link & Phelan, 2001).

Discrimination – The unfair or adverse treatment of a person or group of people, often based on stigmatising views about particular characteristics. Unlawful discrimination occurs when it is based on grounds and in an area of public life that are made unlawful by legislation.

Public stigma – Negative thoughts, feelings and behaviours held or expressed by individuals towards people who experience mental ill-health (Council of Australian Governments Health Council, 2017). As a result of public stigma, people living with mental ill-health are negatively categorised, othered, and lose status and power in society (Groot, 2021). This leads to widespread discrimination against people with mental ill-health, which limits a range of life opportunities (Canadian Centre on Substance use and Addiction, 2019).

Self-stigma – The process in which a person with personal lived experience becomes aware of public stigma, agrees with those stereotypes, and internalises them by applying them to the self. The person comes to believe these negative messages or stereotypes about mental ill-health and applies these to themselves (Productivity Commission, 2020).

Structural stigma – When laws, policies, and practices enable unfair treatment of people who experience mental ill-health (Livingston, 2013). This includes where it is much harder for people who experience mental ill-health to access vital services and to participate in society.

Perceived stigma – A person's awareness or perception that the public holds prejudice, negative views or engages in discriminatory behaviour towards people who experience mental ill-health.

Anticipated stigma – A fear that prejudice, discrimination and stereotyping will be directed at the self from others in the future. The experience of perceived stigma is central to anticipated stigma, and often results in withdrawal from opportunities.

Associated stigma – Stigma by association involves disapproval towards those who associate with people whose experiences are stigmatised. It can affect family, friends, carers, support people and health workers.

Mental ill-health – Mental ill-health is an umbrella term to describe experiences of psychological distress or mental illness, including experiences of trauma, suicidality, and alcohol and other drug issues. In defining mental ill-health in this way, we acknowledge that some individuals may have experiences which meet this definition, but do not describe them in this way (see Language matters).

Mental health problem – Mental health problem refers to a specific instance of mental ill-health. Within the survey, we provided the following definition to respondents:

“By a ‘mental health problem’ we mean a problem that affects how you think, feel, behave, or interact with other people, and generally lasts at least several weeks.

Mental health problems could include, for example, depression, anxiety disorders, eating disorders, schizophrenia, bipolar disorder, or personality disorders.”

Lived or living experience of mental ill-health – People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress.

For Aboriginal and Torres Strait Islander people, lived experience recognises the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

Carer or support person – A person who plays a vital role in supporting a person experiencing mental ill-health. They provide emotional or practical support. They may be a parent of someone with mental ill-health, or an adult caring for a partner, parent, sibling, other family, kinship group member or friend, or a child who looks after a family member with mental ill-health, such as a parent or sibling. Within the survey, we provided the following definition to respondents:

“You are considered a support person if you provide emotional or practical support to help a person living with a mental health problem. You may be supporting or caring for a parent, child, partner, friend or other important person in your life with a mental health problem. Or you could be supporting someone in the workplace or another similar setting”.

LGBTIQA+ – An acronym that is a way of referring collectively to people who are lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, or questioning, asexual and those who have other diverse experiences regarding sexual orientation, gender and sex characteristics.

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