beyondblue
the national depression initiative
www.beyondblue.org.au

15 December 2012

Ms Julie Dennett
Committee Secretary
Standing Committee on Legal and Constitutional Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Re Exposure Draft legislation for the Human Rights and Anti-Discrimination Bill 2012

Dear Ms Dennett

*beyondblue: the national depression and anxiety initiative* welcomes the opportunity to make a submission to the Standing Committee on Legal and Constitutional Affairs, in relation to this Exposure Draft Bill.

*beyondblue* supports a number of the reforms to Commonwealth anti-discrimination law recommended in the draft. *beyondblue* welcomes the government's focus on consolidating anti-discrimination legislation and simplifying the process for making a discrimination complaint, including **the protection against intersectional discrimination.** *beyondblue's* Position Statement "Stigma and discrimination associated with depression and anxiety, August 2012" provides a comprehensive overview of the impact of stigma and discrimination, both as a risk factor for developing depression and/or anxiety or **as a** result of being identified as experiencing depression and/or anxiety (Attachment 1).

In addition, *beyondblue* welcomes the inclusion of **sexual orientation and gender identity as protected attributes** under the draft legislation. This is consistent with the evidence cited in the *beyondblue* Position Statement "Depression and anxiety in gay, lesbian, bisexual, trans and intersex populations, May 2012" which highlights the abundance of research demonstrating that discrimination is a major risk factor contributing to increased prevalence of both depression and anxiety among gay, lesbian, bi, trans and intersex people (Attachment 2).

PO Box 6100, Hawthorn West VIC 3122
Tel: 03 9810 6100
Fax: 03 9810 6111
Web: www.beyondblue.org.au
Email: bb@beyondblue.org.au
*beyondblue* info line: 1300 22 4636

ABN 87 093 865 840
Beyond Blue Limited

*beyondblue: opening our eyes to depression and anxiety across Australia*

*Her Excellency Ms Quentin Bryce, AC – Governor-General of the Commonwealth of Australia – Patron*

*beyondblue* does however request that this committee **revisit our recommendation to prohibit discriminatory requests for information relating to experiences of mental illness within the insurance industry.** This is described in full under Recommendation 8 in our response to the anti- discrimination laws discussion paper (February 2012). I attach a copy of this submission for your reference (Attachment 3).

Further to this, in order to ensure that the legislation protects *all* Australians, *beyondblue* proposes that the bill **should specifically include all sex identities as protected characteristics,** including intersex people. In the present draft, the definition of gender identity in the legislation and the explanatory notes confounds gender and sex. All sex identities need to be included as protected characteristics and consultation with organisations and individuals who are themselves, or represent intersex persons should be conducted to ensure the legislation provides anti-discrimination protection for intersex people.

Finally, I urge the this committee to recommend that the Australian Human Rights Commission or another relevant agency be resourced to **effectively communicate any changes to legislation** that are passed into law. By educating the Australian community about the changes to anti-discrimination legislation the government will help to drive cultural change and inform policies and behaviour consistent with the legislation.

Yours sincerely

Ms Kate Carnell AO
Chief Executive Officer
*beyondblue*

# *beyondblue* Position Statement

## Stigma and discrimination associated with depression and anxiety[1]

## August 2012

### *beyondblue* position

People with depression and anxiety experience significant levels of stigma and discrimination. This has a negative impact on the quality of life of people with depression and anxiety, and their carers, affecting access to treatment, employment, housing, insurance and personal relationships. The stigma and discrimination associated with depression and anxiety may be worse than the illnesses themselves.

In addition to the significant stigma and discrimination associated with depression and anxiety, experiencing discrimination (for example, ethnic, race, sex, gender or sexuality-based discrimination) is a risk factor for poor mental health and wellbeing.[1,2,3,4,5] Efforts to reduce the stigma and discrimination of depression and anxiety should support broader anti-discrimination strategies. This is an important part of acknowledging and responding to the complexity of stigma and discrimination, and the impact of experiencing multiple forms of stigma and discrimination on mental health and wellbeing.

More research is needed to understand better the different types of stigma that are associated with depression and anxiety, and effective ways to reduce that stigma and discrimination. This additional research is particularly important to understand the stigma associated with anxiety, which has not been well researched.

While a greater understanding of stigma is needed, research findings have already demonstrated that there are effective ways to reduce stigma. These include people with stigmatising attitudes:

- having more contact with people who have depression and anxiety
- being provided with factual information that challenges the inaccurate stereotypes they hold of people with depression and anxiety.

---

[1] This position statement relates to the stigma and discrimination associated with depression and anxiety. It is acknowledged that experiencing discrimination (for example, ethnic, race, sex, gender or sexuality-based discrimination) is a risk factor for poor mental health and wellbeing. While reducing this discrimination is an important priority for *beyondblue*, this position statement relates only to the stigma and discrimination that is directly associated with depression and anxiety. More information on the impact of discrimination on mental health is available in the '*beyondblue Position Statement: Depression and anxiety in gay, lesbian, bisexual, trans and intersex populations'.*

It is essential that stigma-reduction strategies are developed and implemented in a collaborative, sustainable and multisectoral way. These strategies should be led by people with depression and anxiety and their carers, and be supported by system-level reform and policies, that influence national attitudes and behaviours. There is an important role for stigma-reduction approaches being implemented at different levels - targeting individuals, organisations, communities and the policies of government and private institutions.

Addressing the stigma and discrimination associated with depression and anxiety is a core component of reducing the impact of these conditions, and is a key priority for *beyondblue*. Reducing stigma and discrimination is an essential part of developing an Australian community that understands depression and anxiety, empowers people to seek help, and supports recovery, management and resilience.

**Key terms**

There are different types of stigma associated with depression and anxiety, which include:

- **personal stigma** – a person's stigmatising attitudes and beliefs about other people *("People with depression should snap out of it.")*
- **perceived stigma** – a person's beliefs about the negative and stigmatising views that other people hold *("Most people believe that a person with depression should snap out of it.")*
- **self-stigma** – the stigmatising views that individuals hold about themselves *("I should be able to snap out of my depression.")*
- **structural stigma** – the policies of private and governmental institutions that restrict the opportunities of people with depression and anxiety *("Mental health services and research don't deserve as much funding as other health problems.")*. Structural stigma may be either intentional or unintentional.

To reduce stigma, there are three major strategies:

- **Educational** – This includes information resources (for example, books, flyers, movies, websites etc) which challenge inaccurate stereotypes and replace them with factual information. This approach responds to the cognitive component of stigma.
- **Contact** – This includes interpersonal contact with people with depression/anxiety. This approach addresses the emotional component of stigma.
- **Protest** – This involves highlighting the injustices of stigma, and requesting or demanding the attitudes be suppressed (for example, the SANE StigmaWatch initiative). This approach relates to the behavioural component of stigma. Research suggests that this strategy does not result in significant changes in attitudes or behaviours; however there may still be a role for protest approaches in suppressing stigmatising views in the media.

**Key *beyondblue* messages about stigma and discrimination associated with depression and anxiety**

- There is considerable stigma associated with mental illnesses and suicide. The level and type of stigma differs across illnesses. Most people with depression and anxiety report experiencing stigma.

- There are different types of stigma associated with depression and anxiety. This includes personal stigma, perceived stigma, self-stigma and structural stigma.

- These four different types of stigma have a significant and negative impact on people with depression and anxiety. This includes preventing people from using health services; limiting access to employment, housing, and insurance; and impacting on personal relationships. Stigma also has a negative impact on the broader community, due to the substantial costs associated with the stigma and discrimination.

- Stigmatising attitudes can lead to discriminatory behaviour; however, more research is needed to understand this link better, as well as effective ways to reduce discrimination. More research is also needed to understand more clearly the stigma associated with anxiety disorders.

- International research suggests that there is increased understanding of mental health within the community; however there have not been significant changes in levels of stigmatising attitudes. Within Australia, some stigmatising attitudes have decreased over time (for example, the belief that depression is a weakness of character), while other stigmatising attitudes have increased (for example, the belief that people with depression are dangerous).

- There are three major strategies to reduce stigma – educational approaches, contact approaches and protest approaches. Research findings suggest that increasing contact with people with depression and anxiety is the most effective approach; while educational approaches are also effective. Contact approaches should be targeted, local, credible and continuous.

- To reduce the stigma and discrimination associated with depression and anxiety effectively, a comprehensive, long-term, collaborative and multi-sectoral approach is needed.

**Stigma overview**

**Stigma marks a person as 'different'**[6]. The World Health Organization (2001) defines stigma as *"a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society."*[7] Scrambler (1998) describes stigma as *"...any attribute, trait, or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she interacts, and elicits some form of community sanction."*[8]

Stigmatising attitudes, like other attitudes, can be described as having **three components** – emotional (for examples, feelings of concern); cognitive (for example, believing that someone is dangerous); and behavioural (for example, avoiding someone with depression / anxiety).[9,10,11]

There are **different types of stigma** associated with depression and anxiety, which include:[12,13,14,15,16,17]

- **personal stigma** – a person's stigmatising attitudes and beliefs about other people *("People with depression should snap out of it.")*
- **perceived stigma** – a person's beliefs about the negative and stigmatising views that other people hold *("Most people believe that a person with depression should snap out of it.")*
- **self-stigma** – the stigmatising views that individuals hold about themselves *("I should be able to snap out of my depression.")*
- **structural stigma** – the policies of private and governmental institutions that restrict the opportunities of people with depression and anxiety *("Mental health services and research don't deserve as much funding as other health problems.")*. Structural stigma may be either intentional or unintentional.

While discriminatory behaviour is a core component of stigma, most research has focused on the emotional and cognitive components of stigma, and behavioural *intentions*, rather than *actual* behaviour.[18] It is also important to acknowledge that some individuals may not be aware that they have stigmatising attitudes, which may lead to subtle forms of discrimination.[19]

**Links between stigma and depression and anxiety**

The stigma associated with depression and anxiety disorders is complex. Most people with depression and anxiety report experiencing stigma relating to their mental illness.[20] The level, type and experience of stigma may be influenced by factors such as the illness itself, the age and gender of the person, and culture.[21] Much of the research has focused on the stigma associated with mental illnesses broadly, depression and schizophrenia.[22] **Further research is needed to understand the stigma associated with anxiety disorders better**, as evidence suggests that it is not appropriate to generalise the stigma associated with depression to anxiety disorders.[23]

**The common elements of stigma** include:[24,25,26,27]
- **perceptions that a person is 'weak, not sick'** – *"My father and my sister don't believe in mental illness. If you can't cope with something it's a weakness of character, not an actual illness."* Consumer
- **perceived dangerousness** – *"All mentally ill are tainted by reports of the extremely unusual 'crazy and dangerous'. As if at any time, they could become horrific mass murderers!"* Consumer
- **beliefs that a person is responsible and can control his/her condition** – *"Most people seem to think depression is...something that is within your character to control."* Consumer

- **feelings of guilt, shame and embarrassment** – *"You keep it to yourself because you're ashamed of it."* Consumer
- **a reluctance to disclose a diagnosis, due to concerns about discrimination and harassment** – *"When he [husband] was looking at applying for jobs, his psychiatrist said, 'I wouldn't mention he's got a mental illness. They don't need to know'."* Carer
- **a desire for social distance** - *"I lost quite a few friends because they were scared of me or didn't know how to treat me."* Consumer

Reavley and Jorm (2011) conducted a national mental health literacy and stigma survey which measured the stigmatising attitudes towards people with a range of disorders including depression, social phobia and posttraumatic stress disorder (PTSD). This data indicates that **levels of perceived stigma are considerably higher than levels of personal stigma**.[28] For more information see Attachment A. People with depression and anxiety think this has a significant negative impact on their lives:

> *"The stigma doesn't have to be real, only perceived to be dangerous."*
> Consumer

Additional research is needed to understand the differences in perceived and personal stigma better. Differences may be attributable to the social desirability bias (in which people tend to hold back negative attitudes, and behave in a way that is considered to be more socially desirable), and / or people overestimating the levels of stigma in the community.[29]

Schomerus and colleagues (2012) have conducted a systematic review and meta-analysis of public attitudes about mental illness in industrialised countries.[30] This review suggests that **while there is an improved understanding of mental health, there have been no changes in the stigmatising attitudes toward people with mental illness**. Reavley and Jorm (2012) report that **within Australia, some aspects of the stigma associated with depression have improved over time** (such as a decreased desire for social distance, and a decrease in the belief that the illness is a weakness of character); however, the belief that people with depression are dangerous has increased.[31]

When considering the stigma associated with depression and anxiety, it is important to acknowledge the **limitations of research** in this field. Measuring attitudes is difficult, and is often done in a way that oversimplifies complex issues, and may not reflect attitudes to a 'real person'.[32,33] Measurements are often based on assumptions that attitudes can be measured quantitatively, and the measures have the same meaning for all people. These assumptions are not always justified, and may limit the usefulness and appropriateness of research findings.[34] Another common limitation of stigma research is the impact of the social desirability bias.[35] This effect may be more pronounced in the evaluation of public education campaigns aiming to reduce stigma, due to the messages of the campaign, which reinforce the socially desirable responses.[36]

**The impact of stigma on people with depression and anxiety**

> *"I think the reality is...the stigma of mental illness is, in some ways, worse than the illness itself. Unless the stigma can be removed to such a degree that it does not become a barrier to acknowledgement, treatment and hope for the future, the reduction of some mental illnesses will be nothing but a pipe dream."* Consumer

Stigma can have a significant impact on access to health services and treatment, employment, housing, insurance, and personal relationships. [37,38] Stigma affects both people with depression and anxiety, and their carers.

> *"Stigma affects all areas of my life as a family carer. Family, employment, social life..."* Carer

## *Access to treatment*

Stigmatising attitudes impacts on access to treatment and mental health services. Stigma may contribute to feelings of embarrassment and shame, which may decrease the likelihood of seeking help, increase psychological distress, and reduce treatment adherence. [39,40]

> *"...I refused the professional help I so desperately needed. The simple reason I didn't get this help was due to the stigma of having a mental illness. I believed it would have cost me my career. The tragic outcome was that I did end up losing my career and my illnesses became far worse...."* Consumer

People with depression and anxiety report experiencing stigmatising attitudes from health professionals, which may impact on recovery and physical health.[41]

> *"I have...found that some of the young GPs who sit in as a locum tend to not take your concerns in regard to chest pains, pain and weakness in the left arm etc. seriously once they read in your notes that you have mental illness...We are not hypochondriacs or attention seekers. We are just a regular person who has a concern in regard to their health."* Consumer

> *"A few years ago I began having small seizures and I went to see a doctor about this. The doctor's immediate assumption was that I was having anxiety attacks and that I should see my psychiatrist. I found this to be very patronising, as I know that these were not anxiety attacks...my psychiatrist...referred me to a neurologist. I have since been diagnosed with partial epilepsy. My concern with this is that if my general practitioner had been the sole health care provider with regards to my depression / anxiety then my epilepsy may not have been diagnosed at all."* Consumer

Research findings also indicate that a concern about others' reactions to seeking help, including reactions from health professionals, family members, friends and work colleagues, may decrease the likelihood of using mental health services, and seeking help from informal sources.[42,43]

Wright, Jorm and Mackinnon (2011) suggest that the relationship between stigma and help-seeking is complex, with different components of stigma being associated with different attitudes towards help seeking.[44] For example, among young people, supporting the 'weak

not sick' and 'social distance' components of stigma are likely to reduce an individual's willingness to seek help for a mental health problem. In contrast,  believing that a person with a mental illness is 'dangerous' and 'unpredictable' is likely to increase an individual's willingness to seek help. [45,46]  Both self and perceived stigma appears to impact help-seeking, with self-stigmatising views being particularly influential.

### *Employment*

Stigma is a significant barrier to participating in employment.[47,48,49,50] Stigma may be presented in many different ways within workplaces. This can include mental illness symptoms being construed as signs of laziness or incompetence, which can contribute to people feeling shameful about their experiences:[51]

> *"You just get made to feel lazy, like I just couldn't be bothered turning up to work. I ended up having to resign."* Consumer

> *"...When I was suffering, I was ashamed. I didn't let people know what I was going through. In the workplace, everybody thinks 'oh, everybody's competent, should be in charge'. You think, 'how can I tell somebody I'm anxious?'"* Consumer

> *"There is definite stigma and discrimination…this includes being questioned about my competence due to my mental illness, despite consistently performing well when I was at work… [and] being 'spoken to' on numerous occasions about my need to have time off despite being forthcoming about the fact that I had a mental illness. I felt very stigmatised against, as other colleagues who took time off….were not questioned as I was, and their level of competence was never in doubt as mine was."* Consumer

Stigma in the workplace may lead to discrimination during recruitment, returning to work, promotional opportunities, and acknowledging workplace-related mental health problems:[52]

> *"I think employers are reluctant. It's very hard if you have any sort of disability, let alone a mental illness that you're open about, to then be able to get employment."* Consumer

> *"We went through the Comcare system, which is the federal equivalent of Workcover. You've all seen the Workcover 'return to work' ads. That's great if you've broken a leg or hurt your back. We had a workplace that was not interested in re-employing him [husband], that was not looking to find him another job. Our problem was we were going through a system that didn't recognise mental illness."* Carer

> *"Presenting a medical certificate with depression, anxiety or even stress is fraught with danger."* Consumer

Stigma also discourages people from disclosing a mental illness to employers.[53] An Australian study reported that 57 per cent of people with a mental illness had disclosed their illness to an employer, and of these, 67 per cent reported it being helpful in providing better support, more understanding, and less stress. The major reasons for not disclosing were

embarrassment, fear of discrimination, and concern about how the disclosure would impact on employment opportunities.[54,55]

> *"I suffer from anxiety and mild depression and I have never told anyone other than my wife. The reason being is the stigma and discrimination that still surrounds the illness. I would go as far as saying that my anxiety has played a big part in me not getting a job in my chosen profession."* Consumer

### *Housing*

Stigma may impact on obtaining appropriate housing.[56,57] Corrigan (2004) suggests that the stigma of mental illness may impact on rental housing, through the landlords refusal to rent to people with a mental illness; setting different terms and conditions for rental agreements; and not allowing reasonable adjustments to be made (for example, allowing family members to co-sign a lease).[58] SANE Australia (2008) reports that in a housing survey, nearly 90 per cent of respondents who had a mental illness believed that they had been discriminated against in their search for appropriate housing.[59]

### *Insurance*

> *"...Insurance companies are the worst for it! The stigma of 'Someone has been hospitalised for depression three years ago = don't cover them for income protection because they are unwell'. Lots of things change in three years, including depression which has been effectively managed."* Carer

An example of structural stigma is demonstrated through the substantial difficulties people with depression and anxiety face when seeking different types of insurance products (e.g. life, income protection, travel, health) that are otherwise readily available to people without a history of mental illness.[60] A survey conducted by *beyondblue* and the Mental Health Council of Australia (MHCA) in 2010 of consumer experiences of insurance found that over 35 per cent of respondents strongly agreed that it was difficult for them to obtain any type of insurance due to them having experienced mental illness.[61] This almost doubled, increasing to 67 per cent, for life and income protection insurance.[62] Survey respondents reported experiencing significant discrimination when applying for insurance products and making claims against their policies:

- *"My broker said that income protection insurance would be too hard to get because of my history, so don't bother applying and I was advised it would be declined and thus didn't take it further…"* Consumer
- *"…I decided not to take up the product for the time being because I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc.) made me feel."* Consumer

### *Personal relationships*

Stigma may adversely affect personal relationships.[63] Within families, people with depression and anxiety suggest that experiences of stigma include a discomfort to talk about mental health issues, a denial of problems, and a dismissal of issues:[64]

- *"Some of my family members are very patronising."* Consumer

- *"My parents played the mute game. They didn't talk about it. I think they were uncomfortable."* Consumer
- *"We spent a lot of years pretending there was something else wrong with [husband]. He knew what was wrong [depression] but he didn't want anybody to know."* Carer
- *"I didn't tell my mother I'd been medicated for depression for quite some years. [When I did], my mother's response was, 'oh what rubbish, you're not depressed'."* Consumer
- *"They [my husband's family] don't understand that there are times where his behaviour may be different because he is unwell (bipolar / anxiety) – but they consider this as him being rude and weak, they then don't understand he needs to be treated gently, instead they are very tough on him, which makes the situation worse. A lack of understanding is very frustrating."* Carer

Feelings of shame, the desire to protect the family name, and competing need for attention among family members may contribute to the heightened levels of stigma experienced within families.[65]

Stigma may also impact on the development of new relationships:
*"I am at the point in my treatment (and life) that I feel well enough to want to pursue a romantic relationship...On top of the 'normal' issues faced by a person in my position, I feel the added weight associated with suffering depression. While much of this is self-stigma (She will head for the hills if she knows I have depression; How long do I have to wait before I tell her? How am I going to explain some of the more 'intimate' side effects of the medication? etc.), there are also attitudes I hear in general conversations with acquaintances ('No, steer clear, if he has depression - it is too much hard work' or 'He will only bring you down with him').* Consumer

**The impact of stigma on society**

In addition to stigma impacting on people with depression and anxiety and their carers, it also has a significant and negative impact on the broader society. There are substantial costs associated with depression and anxiety disorders – for example, it is estimated that depression in the workforce costs the Australian society $12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover.[66] A significant proportion of the cost of depression and anxiety stems not from the conditions themselves, but from the stigma associated with the conditions.[67] Gelb and Corrigan (2008) suggest that the overall cost of stigma includes lost employee productivity; higher taxes; higher insurance premiums and expenses; legal costs relating to cases of discrimination and depression and anxiety that may be attributable to workplace environments; higher treatment costs due to delays in seeking help; and lower rates of 'purchasing power' and consumption, due to under and/or unemployment.[68] These costs demonstrate the importance of reducing stigma and discrimination, not only to improve the experiences and quality of life for those people experiencing depression and anxiety and their carers, but also to benefit the community.

**Stigma within different population groups**

The level and type of stigmatising attitudes held by different population groups is difficult to determine, due to the complexity of stigma, and the different approaches to measurement.[69,70] Jorm, Reavley and Ross (2012) and Jorm and Oh (2008) suggest that it is

important to focus on specific aspects of stigma, that have been measured in consistent ways, to determine whether there are differences within and between population groups.[71,72] When considering specific types of stigma, there are differences in the characteristics of people who may hold more stigmatising views. For example, for the 'belief in dangerousness' component of stigma:[73]

- there is no consistent association between the belief and age or gender
- the belief tends to be lower in better educated people
- there are some cross-national and cross-ethnic differences in the belief.

Comparatively, for the 'desire for social distance' component of stigma:[74]

- the desire is higher in older than in younger adults
- the desire declines during adolescence
- there are no reliable gender differences
- there is a weak association with low education
- there are some major cross-national differences.

Additional factors to consider when reviewing the stigmatising attitudes held within and between population groups, are the differences in self, personal and perceived stigma. Griffiths, Christensen and Jorm (2008) suggest that the only consistent predictor for holding higher levels of stigmatising attitudes for both personal and perceived stigma is experiencing psychological distress.[75] The relationship between stigmatising attitudes, and factors such as sex, education, and levels of understanding of depression, differ for personal and perceived stigma (for example, levels of personal stigma are higher among males, but no sex differences have been reported for levels of perceived stigma).[76] A review of levels of self-stigma, conducted by Livingston and Boyd (2010), suggests that there does not appear to be any consistent or strong correlations between socio-demographic factors and levels of self-stigma.[77]

These research findings suggest that **it is difficult to generalise about population groups and/or characteristics that are associated with higher or lower levels of stigmatising attitudes**.

**Research evidence on effective stigma-reduction approaches**

> *"I would love to be able one day to discuss my illness openly with all my friends, family and work colleagues without fear of retribution. This can only be done by extensive education of the wider community and associated healthcare professionals. People are always afraid of what they don't understand."* Consumer

> *"I believe it would be beneficial to share stories on how people have renegotiated their lives and to find new ways of being...It would be so worthwhile to hear stories of people who have recurring depression and/or anxiety who are leading fulfilling lives."* Consumer

Stigma-reduction approaches consist of three major strategies:[78]

- **Educational** approach – This includes information resources (for example, books, flyers, movies, websites etc) which challenge inaccurate stereotypes and replace

them with factual information. This approach responds to the **cognitive** component of stigma.

- **Contact** approach – This includes interpersonal contact with people with depression/anxiety. This approach addresses the **emotional** component of stigma.
- **Protest** approach – This involves highlighting the injustices of stigma, and requesting or demanding the attitudes be suppressed (for example, the SANE StigmaWatch initiative[79,80]). This approach relates to the **behavioural** component of stigma. Research suggests that this strategy does not result in significant changes in attitudes or behaviours; however there may still be a role for protest approaches in suppressing stigmatising views in the media. [81]

Educational and contact approaches both significantly reduce stigmatising attitudes. For adolescents, educational approaches may be more effective. These approaches are also beneficial as they are generally low cost and have broad reach. However, for adults, **contact approaches are the most effective ways to reduce stigma**.[82] As the educational, contact and protest approaches respond to different components of stigma – cognitive, emotional and behavioural components – improvements in stigma may be best achieved by drawing on a range of approaches.

Corrigan's (2011) research indicates that there are **five principles that need to be implemented to respond to stigma effectively**:[83]

1) **Contact is fundamental.** This involves *"planned interactions between people with mental illness and key groups",* and to be most effective it should be face-to-face contact. Videotaped contact is also effective, however to a lesser degree than face-to-face. [84]
2) Contact needs to be **targeted.** It should focus on key groups such as employers, landlords and healthcare providers, and aim to change negative behaviours with affirming behaviours (for example, employers hiring more people with depression/anxiety, healthcare providers delivering high-quality and non-stigmatising services).
3) **Local** contact programs are more effective. These may include geographical, political, social, cultural and other diversity factors.
4) Contact must be **credible.** It should be with individuals who are similar in ethnicity and socioeconomic status; it should also be with individuals who are in a similar role; and the contact should be with a consumer who is in recovery.
5) Contact must be **continuous.** Multiple contacts should occur, and there should be a variety of messages, venues and opportunities.

Corrigan's principles of responding to stigma are supported by **recommendations from people with depression and anxiety on the most effective ways to reduce stigma**:

> *"Being around people (e.g. socialising, formal meetings etc.) who live with mental illness, in my view, can be a real eye-opener for some, as can sitting in an audience where the speaker is talking about their direct experience of mental illness(es). I believe that to be heard and understood, the message about living with mental illness needs to concentrate on the positive possibilities for individuals and communities where there is support and engagement, as opposed to the negatives."* Consumer

*"We need to emphasise that normal everyday well-adapted people suffer from mental illness and are capable of leading normal productive lives. I must say, I have made it my mission to disclose my mental illness and be very open about it. I do enjoy it when I get a positive reaction, which is most of the time. It does so much to change public perception. I am a fit, well-groomed, sensible, intelligent woman and I will do as much as I can to remove the stigma attached, even if it means going out on a limb at time."* Consumer

*"I try to be casual and open about my illness. It feels much better to be open about it and able to speak freely. I explain the illness, which helps them to understand my behaviour better, and it is reassuring for them to see that I can function normally and still be affected."* Consumer

*"Listen to someone who has experience...I think...the experience needs to come from 'like' i.e.: solicitor to solicitor, healthcare to healthcare etc., as I think there still exists an attitude that it doesn't happen to people like me. Follow up required as we all need reminding."* Consumer

While research has demonstrated that contact and educational approaches are effective in changing stigmatising attitudes and intentions, **additional research is needed to assess how these approaches impact on actual behavioural change**.[85] There is also a need for research to develop and test practical, 'real world', interventions that can be implemented in a wide-scale, sustainable, and ongoing manner. This is essential for translating the benefits achieved through research trials to real reductions in stigmatising attitudes and behaviours within the community.

**The national policy framework**

Reducing the stigma and discrimination associated with depression and anxiety is one of the key aims of Australia's national mental health policy and reform agenda. The need to reduce stigma is identified in the:

- *National Mental Health Policy* (2008) – An aim of the Policy is to *"reduce the impact of mental health problems and mental illness, including the effects of stigma, on individuals, families and the community."*[86]
- *Fourth National Mental Health Plan 2009 to 2014* – The Plan recognises that people with depression and anxiety and their families continue to experience stigmatising attitudes in the media and community, and are at risk of being discriminated against in areas such as employment and housing. The Plan proposes the development and implementation of a sustained and comprehensive national stigma-reduction strategy.[87]
- *Ten Year Roadmap for National Mental Health Reform – Consultation Draft* (2012) – The draft roadmap proposes *"developing and delivering a national stigma-reduction and anti-discrimination campaign by working with mental health services and support sectors, consumers, carers and families, media and other experts"* to help promote good mental health and wellbeing, and prevent mental illness and suicide.

**beyondblue initiatives addressing stigma and discrimination**

Reducing the stigma and discrimination associated with depression and anxiety is one of the key priorities of *beyondblue.* A comprehensive approach to community awareness-raising and stigma-reduction has been implemented, which includes educational, contact and protest approaches. This includes the following initiatives:

- **National advertising campaigns and supporting resources** – an **educational approach** - Campaigns have been developed to cover a range of disorders (such as depression, anxiety, perinatal depression); life stages (for example, youth, older people); and settings (for example, rural communities). *beyondblue's* campaigns are based on extensive quantitative and qualitative research with people with depression and anxiety and their carers, and provide insights into personal experiences. Campaign messages are disseminated and promoted via print, television, radio, cinema advertising, advertising in public restrooms, outdoor billboards, and community events and forums. *beyondblue* has also developed a comprehensive suite of free information and resources, including translated materials, which are disseminated to individuals, community groups, health centres, libraries, schools, universities, workplaces and many other settings.

- **Media coverage** – A combined **educational, contact and protest approach** - *beyondblue* has achieved widespread media coverage of depression, anxiety and *beyondblue* programs.  Within a six-month period, there are up to 6,500 mentions of *beyondblue* in press, radio, television and online media, with the cumulative audience/circulation of this coverage being almost 123 million. The increased media coverage of depression and anxiety, and the promotion of personal experiences, leads to greater awareness of mental health, and may contribute to decreasing levels of stigma and discrimination.

- *beyondblue* **Ambassador program** – a **contact approach** - *beyondblue* has a pool of ambassadors that includes people with depression and/or anxiety; carers of people with depression and/or anxiety; and high-profile people who have experienced or cared for someone with depression and/or anxiety. The ambassadors talk about the consumer and carer experience of depression and anxiety at public events, community forums and to the media.

- *beyondblue* **National Workplace Program** – an **educational and contact approach** - This Program is an awareness, early intervention and prevention program designed specifically for employers and employees in workplace settings. The Program aims to increase the knowledge and skills of staff and managers to address mental health issues, while maintaining a focus on research, policy and best practice.  Independently evaluated in Australia and the UK, the Program has been shown to:
  - increase awareness of depression
  - decrease stigma
  - improve attitudes
  - increase confidence to assist someone to seek help.

- *beyond maturityblues* program – an **educational approach** - This peer education program is delivered in partnership with Councils on the Ageing (COTA), to raise awareness of depression and anxiety and to reduce stigma among older people. The key message of the program is 'having depression or anxiety in not a normal part of ageing'.

- **Discrimination and insurance program** – an **educational and protest approach** - *beyondblue* has been working with the mental health and life insurance sectors since 2001 to improve insurance outcomes for people with a history of mental illness. Since this time, there have been key achievements, including the development of industry-wide guidelines for insurance sector staff, enhanced communication between sectors, clearer complaints-monitoring processes, and the development and dissemination of a consumer guide. *beyondblue* and the Mental Health Council of Australia have also developed a website for mental health consumers and carers that provides information about a range of insurance and superannuation products, and recent issues and developments - [www.mentalhealthandinsurance.org.au](www.mentalhealthandinsurance.org.au)

## Recommendations

To reduce the stigma and discrimination associated with depression and anxiety, long-term, collaborative and multi-sectoral approaches are needed. These should include:

- Conducting research to determine the best way to deliver **combined stigma-reduction strategies that include contact, education and protest approaches**, in a sustainable and ongoing manner
- Facilitating **personal contact** with people who have experienced depression and anxiety, in line with recommendations that contact is **targeted, local, credible and continuous**[88]
- Developing and delivering **educational approaches**, which challenge inaccurate stereotypes, and replace them with factual information
- Continuing to work with  traditional and new **media** to promote accurate and positive portrayals of people living with depression and anxiety, with a particular focus on personal stories
- Targeting stigma-reduction strategies to **respond to particular types of stigma** – personal, perceived, self and structural
- Delivering stigma- and discrimination-reduction interventions in **multiple settings** – for example, workplaces, schools, housing/accommodation services and healthcare centres
- Delivering stigma- and discrimination-reduction interventions across **population groups** with a particular focus on creating sustainable cultural and behavioural change
- Developing initiatives that measure and reduce the **structural stigma** associated with depression and anxiety disorders, including both intentional and unintentional stigma
- Improving the **measurement** of stigma and discrimination, with a focus on **actual behavioural changes**, measured longitudinally, to enable regular monitoring of progress

- Undertaking targeted **research** addressing key questions regarding the stigma and discrimination associated with depression, and in particular, **anxiety disorders**
- Implementing both **structural 'top down' programs** that focus on national attitudes and policies impacting on people with depression and anxiety and their carers, together with **'bottom up' initiatives that are led by people with depression and anxiety and their carers**, health care providers, community groups, schools and workplaces.[89]

## Attachment A – Levels of stigmatising attitudes

**Table 1: Personal and perceived attitudes** – Percentage of respondents who 'agree' or 'strongly agree' with statements about personal and perceived attitudes towards people with depression, social phobia and PTSD[90]

| Statement | Depression | | Social phobia | | PTSD | |
|---|---|---|---|---|---|---|
| | **Personal attitude** | **Perceived attitude** | **Personal attitude** | **Perceived attitude** | **Personal attitude** | **Perceived attitude** |
| Problem is a sign of personal weakness | 13.9 | 53.0 | 16.5 | 55.2 | 12.1 | 41.0 |
| Problem is not a real medical illness | 13.2 | 49.5 | 16.3 | 58.7 | 14.9 | 48.9 |
| Person could snap out of the problem | 20.1 | 53.8 | 20.5 | 56.6 | 19.9 | 49.0 |
| People with this problem are dangerous | 22.0 | 39.1 | 15.5 | 35.1 | 18.0 | 36.8 |
| Avoid people with this problem | 6.4 | 36.6 | 5.2 | 35.5 | 2.9 | 32.6 |
| People with this problem are unpredictable | 53.1 | 69.2 | 41.7 | 62.3 | 49.3 | 62.3 |
| If I had this problem I wouldn't tell anyone | 22.7 | 70.2 | 29.5 | 73.6 | 17.1 | 63.9 |
| I would not employ someone with this problem | 22.7 | 70.5 | 29.5 | 65.1 | 17.1 | 58.1 |
| I would not vote for a politician with this problem | 27.0 | 66.0 | 26.1 | 67.4 | 20.2 | 61.3 |

[1] Global Consortium for the Advancement of Promotion and Prevention in Mental Health. (2008). *The Melbourne charter for promoting mental health and preventing mental and behavioural disorders.* Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, Melbourne.

[2] Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35,* 888 – 901.

[3] Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P. & Pitts, M. (2008). *Feeling queer and blue: a review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people.* La Trobe University: Melbourne.

[4] Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A., 2010. *Writing themselves in 3.* Australian Research Centre in Sex, Health and Society, La Trobe University, Monograph Series no. 78.

[5] McNair, R., Szalacha, L.A., Hughes, T.L., 2011. *Health status, health service use, and satisfaction according to sexual identity of young Australian women.* Women's Health Issues, 21(1), pp 40-47.

[6] Canadian Psychiatric Association (2011). Stigma and discrimination Position Paper. *The Canadian Journal of Psychiatry, 56* (10), 1 – 10.

[7] World Health Organization (2001). *The World Health Report 2001 – Mental Health: New Understanding, New Hope.* Accessed online 13 September 2011: http://www.who.int/whr/2001/en/whr01_en.pdf

[8] Scrambler, G. (1998). Stigma and disease: changing paradigms. *Lancet, 352,* 1054 – 1055.

[9] Haghighat, R. (2001). A unitary theory of stigmatisation. *British Journal of Psychiatry, 178,* 207 – 215.

[10] Wolkenstein, L. & Meyer, T.D. (2009). What factors influence attitudes towards people with current depression and current mania? *International journal of social psychiatry, 55,* 124 – 140.

[11] Vaughan, G.M. & Hogg, M.A. (1998). *Introduction to social psychology, 2nd ed.* Prentice Hall: Victoria

[12] Wright, A., Jorm, A.F. & Mackinnon, A.J. (2011). Labeling of mental disorders and stigma in young people. *Social science and medicine, 73,* 498 – 506.

[13] Griffiths, K.M., Christensen, H. & Jorm, A.F. (2008). Predictors of depression stigma. *BMC psychiatry, 8* (25).

[14] Barney, L.J., Griffiths, K.M., Christensen, H. & Jorm, A.F. (2010). The self-stigma of depression scale (SSDS): development and psychometric evaluation of a new instrument. *International journal of methods in psychiatric research, 19* (4), 243 – 254.

[15] Griffiths, K. (2011). *Of Hitler, stigma and the lancet.* Presentation Stigma Summit Brisbane 10 – 11 October 2011.

[16] Wright, A., Jorm, A.F., Mackinnon, A.J. (2011). Labeling of mental disorders and stigma in young people. *Social science and medicine, 73,* 498 – 506.

[17] Corrigan, P.W., Markowitz, F.E. & Watson, A.C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30* (3), 481 – 491.

[18] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[19] Corrigan, P.W. (2004). *Beat the stigma and discrimination! Four lessons for mental health advocates.* Accessed online 28 November 2011: http://www.stigmaandempowerment.org/images/stories/fourlessonsformentalhealthadvocates.pdf

[20] Barney, L.J., Griffiths, K.M., Christensen, H. & Jorm, A.F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health, 9* (61).

[21] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[22] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[23] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[24] Reavley, N. & Jorm, A.F. (2011). Depression stigma in Australian high school students. *Youth studies Australia, 30* (2), 33 - 40

[25] Jorm, A.F. & Oh, E. (2009). Desire for social distance from people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry, 43,* 183 – 200

[26] Wright, A., Jorm, A.F. & Mackinnon, A.J. (2011). Labeling of mental disorders and stigma in young people. *Social science and medicine, 73,* 498 – 506.

[27] Muir, K., Craig, L., Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers: Final Report.* University of New South Wales

[28] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[29] Calear, A.L., Griffiths, K.M. & Christensen, H. (2011). Personal and perceived depression stigma in Australian adolescents: magnitude and predictors. *Journal of Affective Disorders, 129,* 104 – 108.

[30] Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P.W., Grabe, H.J., Carta, M.G. & Angermeyer, M.C. (2012). Evolution of public attitudes about mental illness. A systematic review and meta-analysis. *Acta Psychiatrica Scandinaica, 125* (6), 440 - 452.

[31] Reavley, N.J. & Jorm, A.F. (2012). Stigmatizing attitudes towards people with mental disorders: changes in Australia over 8 years. *Psychiatry Research,* Epub ahead of print: Mar 12.

[32] Vaughan, G.M. & Hogg, M.A. (1998). *Introduction to social psychology, 2nd ed.* Prentice Hall: Victoria

[33] Jorm, A.F., Reavley, N.J. & Ross, A.M. (2012). Belief in the dangerousness of people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry,* Epub ahead of print Mar 15 2012.

[34] Vaughan, G.M. & Hogg, M.A. (1998). *Introduction to social psychology, 2nd ed.* Prentice Hall: Victoria

[35] Wolkenstein, L. & Meyer, T.D. (2009). What factors influence attitudes towards people with current depression and current mania? *International journal of social psychiatry, 55,* 124 – 140.

[36] Haghighat, R. (2001). A unitary theory of stigmatisation. *British Journal of Psychiatry, 178,* 207 – 215.

[37] Corrigan, P. & Gelb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. *Psychiatric services, 57* (3), 393 - 398

[38] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[39] Calear, A.L., Griffiths, K.M. & Christensen, H. (2011). Personal and perceived depression stigma in Australian adolescents: magnitude and predictors. *Journal of Affective Disorders, 129,* 104 – 108.

[40] Kelly, C.M. & Jorm, A.F. (2007). Stigma and mood disorders. *Current opinion in psychiatry, 20,* 13 – 16.

[41] Mental Health Council of Australia (2011). *Consumer and carer experiences of stigma from mental health and other health professionals.* Accessed online 8 December 2011: http://www.mhca.org.au/index.php/information-and-publication/159-stigma

[42] Barney, L.J., Griffiths, K.M., Christensen, H. & Jorm, A.F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health, 9* (61).

[43] Barney, L.J., Griffiths, K.M., Christensen, H. & Jorm, A.F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health, 9* (61).

[44] Wright, A., Jorm, A.F., Mackinnon, A.J. (2011). Labeling of mental disorders and stigma in young people. *Social science and medicine, 73,* 498 – 506.

[45] Wright, A., Jorm, A.F., Mackinnon, A.J. (2011). Labeling of mental disorders and stigma in young people. *Social science and medicine, 73,* 498 – 506.

[46] Yap, M.B.H & Jorm, A.F. (2011). The influence of stigma on first aid actions taken by young people for mental health problems in a close friend or family member: findings from an Australian national survey of youth. *Journal of Affective Disorders, 134,* 473 – 477.

[47] McAlpine, D.D & Warner, L. (2002). *Barriers to Employment among Persons with Mental Illness: A Review of the Literature.* Accessed online 19 April 2011: http://www.dri.illinois.edu/research/p01-04c/final_technical_report_p01-04c.pdf

[48] The Sainsbury Centre for Mental Health (2007). *Briefing 33: Mental health and employment.* United Kingdom: The Sainsbury Centre for Mental Health.

[49] Mental Health Council of Australia (2007). *Let's get to work: A National Mental Health Employment Strategy for Australia.* Accessed online 19 April 2011: http://www.mhca.org.au/documents/publications/Let's%20Get%20To%20Work%20Employment%20Strategy.pdf

[50] Muir, K., Craig, L. & Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers.* University of New South Wales.

[51] Muir, K., Craig, L. & Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers.* University of New South Wales.

[52] Muir, K., Craig, L. & Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers.* University of New South Wales.

[53] Mental Health Council of Australia (2007). *Let's get to work: A National Mental Health Employment Strategy for Australia.* Accessed online 19 April 2011: http://www.mhca.org.au/documents/publications/Let's%20Get%20To%20Work%20Employment%20Strategy.pdf

[54] Mental Health Council of Australia (2007). *Let's get to work: A National Mental Health Employment Strategy for Australia.* Accessed online 19 April 2011: http://www.mhca.org.au/documents/publications/Let's%20Get%20To%20Work%20Employment%20Strategy.pdf

[55] SANE Australia (2011). *Working life and mental illness* (Research Bulletin 14). Accessed online 25 June 2012: http://www.sane.org.au/

[56] Mental Health Council of Australia (2009). *Home truths: mental health, housing and homelessness in Australia.* Accessed online 8 December 2011: http://www.mhca.org.au/index.php/information-and-publication/145-housing-and-homlessness

[57] Corrigan, P.W. (2004). *Beat the stigma and discrimination! Four lessons for mental health advocates.* Accessed online 28 November 2011: http://www.stigmaandempowerment.org/images/stories/fourlessonsformentalhealthadvocates.pdf

[58] Corrigan, P.W. (2004). *Beat the stigma and discrimination! Four lessons for mental health advocates.* Accessed online 28 November 2011: http://www.stigmaandempowerment.org/images/stories/fourlessonsformentalhealthadvocates.pdf

[59] SANE Australia (2008). *Housing and mental illness* (Research Bulletin 7). Accessed online 8 December 2011: http://www.sane.org.au/

[60] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116

[61] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116

[62] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116

[63] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

[64] Muir, K., Craig, L., Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers: Final Report.* University of New South Wales

[65] Muir, K., Craig, L., Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers: Final Report.* University of New South Wales

[66] LaMontagne, A.D., Sanderson, K. & Cocker, F. (2010). *Estimating the economic benefits of eliminating job strain as a risk factor for depression.* Carlton: Victorian Health Promotion Foundation (VicHealth).

[67] Gelb, B.D. & Corrigan, P.W. (2008). How managers can lower mental illness costs by reducing stigma. *Business Horizons, 51,* 293 – 300.

[68] Gelb, B.D. & Corrigan, P.W. (2008). How managers can lower mental illness costs by reducing stigma. *Business Horizons, 51,* 293 – 300.

[69] Jorm, A.F., Reavley, N.J. & Ross, A.M. (2012). Belief in the dangerousness of people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry,* Epub ahead of print Mar 15 2012.

[70] Jorm, A.F. & Oh, E. (2009). Desire for social distance from people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry, 43,* 183 – 200

[71] Jorm, A.F., Reavley, N.J. & Ross, A.M. (2012). Belief in the dangerousness of people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry,* Epub ahead of print Mar 15 2012.

[72] Jorm, A.F. & Oh, E. (2009). Desire for social distance from people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry, 43,* 183 – 200

[73] Jorm, A.F., Reavley, N.J. & Ross, A.M. (2012). Belief in the dangerousness of people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry,* Epub ahead of print Mar 15 2012.

[74] Jorm, A.F. & Oh, E. (2009). Desire for social distance from people with mental disorders: a review. *Australian and New Zealand Journal of Psychiatry, 43,* 183 – 200

[75] Griffiths, K.M., Christensen, H. & Jorm, A.F. (2008). Predictors of depression stigma. *BMC psychiatry, 8* (25).

[76] Griffiths, K.M., Christensen, H. & Jorm, A.F. (2008). Predictors of depression stigma. *BMC psychiatry, 8* (25).

[77] Livingston, J.D. & Boyd, J.E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Social Science and Medicine, 71,* 2150 – 2161.

[78] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[79] SANE Australia (2007). *Stigma and mental illness* (Research Bulletin 4). Accessed online 25 June 2012: http://www.sane.org.au/

[80] SANE Australia (2009). *Stigma, the media and mental illness* (Research Bulletin 10). Accessed online 25 June 2012: http://www.sane.org.au/

[81] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[82] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[83] Corrigan, P.W. (2011). Strategic stigma change (SSC): five principles for social marketing campaigns to reduce stigma. *Psychiatric services, 62* (8), 824 – 826.

[84] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[85] Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D. & Rusch, N. (in press). Challenging the public stigma of mental illness: a meta-analysis of outcome studies.

[86] Australian Health Ministers' Conference (2009). *National Mental Health Policy 2008.* Commonwealth of Australia: Canberra.

[87] Australian Health Ministers' Conference (2009). *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009 – 2014.* Commonwealth of Australia: Canberra.

[88] Corrigan, P.W. (2011). Strategic stigma change (SSC): five principles for social marketing campaigns to reduce stigma. *Psychiatric services, 62* (8), 824 – 826.

[89] Muir, K., Craig, L., Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers: Final Report.* University of New South Wales

[90] Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey on Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45,* 1086 – 1093.

# position statement

# Depression and anxiety in gay, lesbian, bisexual, trans[1] and intersex populations

## May 2012

## *beyondblue* position

*beyondblue's* vision is that the Australian community understands depression and anxiety, empowers people to seek help, and supports recovery, management and resilience. To achieve this vision, *beyondblue* aims to provide national leadership to reduce the impact of depression and anxiety in the Australian community.

*beyondblue* celebrates diversity and promotes social inclusion and equal opportunity in its programs, research and resources. Same sex attraction, sex and gender diversity (see Appendix A, page 8) are within the usual range of human sexual orientation and characteristics.[1] *beyondblue* believes that no one should be excluded or discriminated against because of where their gender, sex or sexuality is located on these continuums. Every member of our society has a right to access safe health care services that affirm our personal identities and work together with individuals and carers to improve health and wellbeing.

It is clear from research evidence and individual stories of depression and anxiety, that discrimination, exclusion and prejudice are contributing factors to the higher rates of depression, anxiety and self harm which are experienced within gay, lesbian, bisexual, trans[1] and intersex (GLBTI) populations compared with the broader population. *beyondblue* is committed to raising awareness about these issues within the community and helping to reduce discrimination.

## Key *beyondblue* messages

- GLBTI populations experience higher rates of depression and anxiety disorders than the general population. There are a range of risk factors that contribute to the development of depression and anxiety. Among GLBTI populations, research clearly indicates that discrimination, verbal and physical abuse, exclusion and prejudice are key contributors to the increased rates of depression, anxiety and self harm.[2,3,4]

- All people have a right to the highest attainable standard of health, both physical and mental, without discrimination on the basis of gender, sex or sexuality.

- Preventing discrimination requires a concerted community effort and a whole of government approach.

- Recognising the rights of all people to safety from discrimination and equality of access to health and social services is an important first step for improving inclusiveness for GLBTI populations.

- The compounding effect discrimination has on depression and anxiety is preventable. Working to remove the discrimination faced by GLBTI populations will assist in improving mental health outcomes.

- *beyondblue's* focus on the prevention and early intervention of depression and anxiety provides a mandate to work with our partners

---

[1] 'Trans' is being used here as an umbrella term to cover a diverse range of experiences of sex and gender and ways of describing oneself such as trans, transgender, transsexual, genderqueer, gender questioning etc. This term has been adopted based on: Aizura, A.Z., Walsh, J., Pike, A., Ward, R., & Jak, 2010. Gender Questioning. A joint project of Trans Melbourne Gender Project, Gay and Lesbian Health Victoria & Rainbow Network Victoria. Accessed at: **http://www.glhv.org.au/node/242**

towards reducing the discrimination faced by GLBTI populations and work together with communities to improve access to appropriate services.

- As a society that values equity and social inclusion, work is needed across a range of areas, including school, sport and social environments, within families, in the workplace and in the provision of health and social care services, to promote inclusive environments that provide welcoming, respectful and safe environments for people of all sexualities, sexes and gender identities.

## Links between prejudice and discrimination; depression and anxiety; and gay, lesbian, bisexual, trans[1] and intersex populations

Everyone lives in the social context of our society. A range of social factors are key determinants of the health and wellbeing of individuals and communities. The World Health Organisation's Commission on the Social Determinants of Health recognised social exclusion as a critical factor which negatively affects the health and wellbeing of people globally. Social exclusion restricts the ability of people to participate in economic, social, political and cultural relationships which in turn negatively impacts on health and wellbeing[5]. Exclusionary processes result in unequal access to the skills, capacities and rights that enable all people to participate fully in society[6].

Equality and freedom from discrimination are fundamental human rights. However, discrimination, abuse, harassment and vilification among people who are gay, lesbian, bisexual, trans[1] and/or intersex are common.[7,8] Discrimination and prejudice have resulted in rejection by families, bullying, violence (including a fear of violence occurring and experiences of violence) or other negative repercussions of being open about ones sexuality, gender and/or sex.[9] Discrimination and a culture of homophobia and transphobia within workplaces can result in limited career choices or progression, as well as a continual anxiety about when and where discrimination might occur.[10]

While the majority of same or both sex attracted, sex and/or gender diverse people lead happy, healthy fulfilling lives, a number of Australian and international studies have demonstrated that prejudice, discrimination and abuse is strongly related to the increased risk for GLBTI populations of developing depression and anxiety, substance use disorders or self harm and thoughts of suicide.[11,12,13] Research studies have found that non-heterosexual people face up to two times as much abuse or violence (including physical, mental, sexual or emotional) than their heterosexual counterparts.[14] A fear of violence is also a strong predictor of depressive symptoms.[15] The experiences of prejudice and discrimination among GLBTI populations adds to the other general biological, social, environmental and psychological risk factors which may lead to depression and anxiety.[16]

The majority of Australians do not hold homophobic beliefs or attitudes, however there is some evidence that a large minority of people (around 35 per cent) do.[17] These attitudes and beliefs have perpetuated the social exclusion of, discrimination towards and prejudice against GLBTI populations.

## Particular at risk population groups/ stages of life

- **Same sex attracted women** are more likely than heterosexual women to have experienced depression during their lifetime[18]. The risk for experiencing depression is greatest for young women aged 16 to 24 and for women over the age of 65.[19]

- **Same sex attracted men** are much more likely to report an experience of depression in the last 12 months than heterosexual men[20]. Younger men who have sex with men are at a greater risk of depression than older men who have sex with men[21].

- **Both sex attracted populations** have significantly higher incidence of mental illness than homosexual or heterosexual populations[22]. The higher rates of depression have been associated with both sex attracted people being subjected to emotional and/or

physical abuse. In an Australian study, bisexual women were more likely to have experienced emotional, physical (including severe) abuse, sexual abuse, and unwanted sexual activity in the last three years than either heterosexual or homosexual women.[23]

- High rates of depression (50-60 per cent) were found in an Australian survey of **trans people**[24]. Research has found a correlation between greater experience of transphobic discrimination and current symptoms of depression among trans people[25]. Research from the United States, with **young trans[1] people** found nearly half had thought seriously about suicide and up to one quarter had attempted to take their own life[26].

- Experience of stigma and discrimination has been found at extraordinarily high levels among the **trans community** in an Australian-New Zealand survey. Almost 90 per cent of survey respondents reported at least one form of stigma or discrimination and two thirds modified their activities due to fear of stigma or discrimination[27].

- Whilst there are few studies of the mental health of **intersex people**, sources of psychological stress may include confusion about sexual identity and gender roles, and treatment issues such as surgery at a young age, surgery without informed consent, and lack of disclosure from parents and health carers. A survey of GLBTI Australians found that approximately 60 percent of intersex people reported having experienced depression, and over 70 percent had seen a counsellor or psychiatrist during the previous five years[28].

- Many **older GLBTI people** have lived through times in which homosexuality was illegal, considered a mental illness and otherwise denigrated.[29,30] This life experience may have a continued effect on older GLBTI people, where current discrimination compounds earlier experiences of discrimination, or results in people not disclosing their sexuality, or gender identity[31]. Some older people face higher levels of social isolation which may

be from both the GLBTI community and the broader community[32]; this may be even higher in rural areas[33].

- Research conducted by La Trobe University since 1998 has consistently demonstrated that the most common place for **young people** to face homophobic abuse and discrimination is at school[34]. Seventy five percent of the young people surveyed attended schools that had no explicit policy to protect same sex attracted or gender questioning young people[35].

In addition to experiencing higher rates of depression and anxiety disorders, GLBTI people also experience higher rates of suicidal behaviour and suicidal ideation.[36]

In the area of racial and ethnic discrimination research suggests that building resilience among people vulnerable to the impact of discrimination and, preventing discrimination before it occurs improves mental health outcomes.[37]

## Overview of the policy framework

### Mental health policy framework

The National Mental Health Strategy is a commitment by the Australian and State and Territory governments to improve the lives of people with mental illness. It provides a framework for national reform, and includes the:

- National Mental Health Policy (2008)

- Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014

- Mental Health Statement of Rights and Responsibilities

While social inclusion and non-discrimination are core components of the Policy, Plan and Statement of Rights and Responsibilities, the National Mental Health Strategy does not acknowledge that discrimination is a key contributing factor to the increased levels of depression and anxiety disorders within GLBTI populations. *beyondblue's* submission to the Revised Mental Health Statement of Rights

and Responsibilities (September 2011) highlighted the importance of considering the needs of GLBTI populations in the Statement.

## National Suicide Prevention Strategy

The National Suicide Prevention Strategy is the Australian Government's national policy on suicide prevention.[38] The strategy, launched in 2000, includes four inter-related components:

- The *Living is for Everyone (LIFE) Framework,* which provides an overarching evidence based strategic policy framework

- The *National Suicide Prevention Strategy Action Framework,* which provides a workplan for suicide prevention activities

- The *National Suicide Prevention Program,* which is the Australian Government funding program for suicide prevention activities

- Mechanisms to promote alignment with state and territory suicide prevention activities and relevant national frameworks

- The LIFE Framework recognises that GLBTI people are at greater risk of suicidal ideation and behaviour.[39] The Australian Government has also recently acknowledged the high suicide rates in the GLBTI community, with the Minister for Mental Health and Ageing announcing in July 2011, that $1.1 million over two and half years was to be granted to the National LGBTI Health Alliance for the *MindOUT* program, which aims to improve mental health and suicide prevention outcomes for the GLBTI population.[40]

## Human rights framework

GLBTI populations have the same human rights as other population groups.[41] **The fundamental rights of non-discrimination and equality before the law** are of key importance for GLBTI populations. These provisions are included in:[42]

- *International Covenant on Civil and Political Rights* (ICCPR)

- *International Covenant on Economic, Social and Cultural Rights*

- *Convention on the Rights of the Child*

- *International Convention on the Elimination of All Forms of Racial Discrimination*

- *Convention on the Elimination of All Forms of Discrimination against Women*

For example, Article 2 of the ICCPR sets out the principle of non-discrimination:[43]

*"Each State Party to the present Covenant undertakes to respect and ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."*

Article 26 of the ICCPR sets out the principle of equality:[44]

*"All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."*

In 2007 the **Yogyakarta Principles**, which confirm that all international human rights laws apply to GLBTI populations, were developed and adopted. While the principles are not legally binding themselves, they interpret already binding agreements from the view point of sexual orientation and gender identity.[45]

In Australia, there are limited legally-binding human rights protections for GLBTI populations.[46] There have been some improvements, with discrimination against same-sex couples being removed from most Commonwealth laws in 2008, and most states and territories providing some protection from discrimination on the grounds of sexuality and sex or gender identity.[47] However, discrimination on the grounds of sexual orientation, sex and gender identity is not unlawful discrimination under federal law.[48,49]

## Social inclusion framework

Australia's national statement on social inclusion, *A Stronger, Fairer Australia* (2009)[50] is founded on five 'pillars for action':

- economic growth
- equitable social policy
- quality services
- strong families and communities
- partnership for change

While discrimination is acknowledged as a factor that contributes to social exclusion, discrimination towards GLBTI populations is not considered within the statement's action plans.

## The service environment

It is important that GLBTI-inclusive practice is considered part of the broader cultural competence requirement of health and human services.[51] The Victorian Ministerial Advisory Committee on GLBTI Health and Wellbeing (2009) has developed a guide for inclusive services, *Well Proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice.* This guide recommends that service providers promote recognition and respect, understanding and responsiveness, and appropriate service delivery, by:

- providing a welcoming environment
- increasing the skills and knowledge of staff through education and training
- improving staff-client communication
- being open about how sexual orientation, gender identity or intersex status may be recorded, used, stored and accessed
- ensuring that appropriate referral services and resources are available
- providing appropriate levels of confidentiality.[52]

*beyondblue* endorses the recommendations in *Well Proud.*

In addition to providing inclusive practice in health and human services, it is also vital that schools and other educational settings provide safe environments for GLBTI people and gender and sexual diversity is supported.[53] Safe Schools Coalition Victoria (2010) outlines strategies to support gender and sexual diversity, including displaying inclusiveness through posters, and actions such as supporting student activism, ensuring all school staff participate in professional development, developing anti-bullying polices inclusive of homophobia and transphobia and ensuring diversity in sex, gender and sexuality is incorporated into sexuality education and other curriculum.[54] Research indicates that school policies which protect students against homophobia/transphobia may influence some of the factors that lead to depression and anxiety among young same sex attracted, sex and or gender diverse people. Policy-based protections were associated with lower suicide rates for students who have not experienced abuse; improved feelings of safety at schools; and more positive feelings about sexuality.[55]

## Relevant *beyondblue* programs, research and evaluation

### GLBTI Mental Health Roundtable, December 2009

In December 2009, *beyondblue* hosted a GLBTI Mental Health Roundtable bringing together key stakeholders to discuss the broad extent of social exclusion, discrimination and the impact on people's mental health; and the variable health and mental health services accessible to GLBTI populations. Key outcomes of the meeting included a commitment from *beyondblue* to develop a community awareness campaign and commission and promote research to identify risk factors for depression and anxiety among GLBTI populations, and highlight those groups most at risk.

### *beyondblue* GLBTI Reference Group

In 2010, a GLBTI Reference Group was formed to assist with scoping the evidence of incidence and risks for depression and anxiety with the GLBTI community to inform the development of a community campaign. The Reference Group includes representatives with a range

of relevant skills and expertise including academics, consumer representatives, public health experts, community organisations from national and state perspectives, people with media and communications skills and a representative from a state government health department.

## Community Awareness Campaign

A new community awareness campaign will be implemented in 2012 to highlight the impact of discrimination as a key contributing factor in the increased prevalence of depression and anxiety among GLBTI populations. The campaign will seek to reduce discrimination by prompting people to question their own attitudes and behaviours and promoting acceptance of diversity. The campaign will also increase understanding of the impact that discrimination has on mental health within GLBTI populations and improve help seeking.

## Community Events

In 2011–12, *beyondblue* supported a range of community events and festivals to strengthen relationships with the GLBTI community and to raise awareness of depression and anxiety. *beyondblue* staff and volunteers distributed bags containing relevant information, fact sheets and wristbands at the Midsumma Festival and the Pride March in Melbourne, the Mardi Gras Fair Day in Sydney, the Feast Festival, Adelaide, the Daylesford Chill Out Festival Carnival Day, Pride Fairday in Perth and Canberra's SpringOut Fairday.

*beyondblue* recognised the International Day Against Homophobia and Transphobia (17 May) with a message of support on *beyondblue's* website.

## SenseAbility

This strength-based resilience program has been designed for those working with young Australians aged 12–18 years. It consists of a suite of modules developed to enhance and maintain emotional and psychological resilience in young Australians. A core component of the program is developing a sense of belonging, with a focus on social inclusion.

## Policy Submissions

*beyondblue* has highlighted the relationship between discrimination and increased risk of depression and anxiety in GLBTI populations in a number of Government policy consultation processes. This has included:

- Consolidation of Commonwealth anti-discrimination laws (February 2012)
- Victorian Mental Health Workforce Strategy (October 2011)
- Revised Mental Health Statement of Rights and Responsibilities (September 2011)
- Opportunities for Participation of Senior Victorians (September 2011)
- Commonwealth Funding and Administration of Mental Health Services (July 2011)

## *beyondblue* GLBTI services and resources

### *beyondblue* info line

*beyondblue's* 24 hour info and referral line provides information, resources and referral pathways in relation to depression and anxiety to anyone in Australia and is staffed by qualified mental health practitioners. Professional development provided to infoline operators includes specific training on the issues experienced by same sex attracted, sex and/ or gender diverse people, and the impact of discrimination on mental health. The referral database that operators use includes a range of services for GLBTI populations, including counselling services, as well as options for family members.

### Dissemination and sharing of materials and resources

Resources which have been distributed at community events, in conference bags and downloaded from the *beyondblue* website include:

- *beyondblue* Fact Sheet 40 – Depression and anxiety in gay, lesbian, bisexual, transgender and intersex people

- *Youthbeyondblue* Fact Sheet 22: Depression and anxiety in young people who are gay, lesbian, bisexual, transgender or intersex

- Feeling queer and blue: A review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people

## Conducting and promoting research

- In 2010 and 2011, the *beyondblue* **Victorian Centre of Excellence** research grants included GLBTI-relevant issues as a research priority. The research projects funded through this program include:

  » **Evaluation of a tailored online same-sex attracted, youth-focused trans-diagnostic mental health and wellbeing program study** (2010)

  » **Building the evidence base of risk and protective factors for depression and anxiety for the GLBTI community** (2011)

  » **The impact of homophobic bullying during sport and physical education participation on same sex attracted and gender questioning young Australians' depression and anxiety levels** (2011)

  » **Exploring the relationships between hazardous drinking, depression and anxiety in lesbian, bisexual and same-sex attracted women: Culture, motivation and behaviour** (2011)

- The second round of the *beyondblue* National Priority Driven Research program called for submissions to address research ***gaps regarding the mental health of GLBTI populations.***

- **The National Centre in HIV Social Research, University of New South Wales** has been commissioned (with funding from Movember's support to *beyondblue*) to conduct a detailed analysis of the role of drug and alcohol use on the diagnosis and management of depression in HIV positive gay men. The study – ***Impact of alcohol***

***and drug use on the diagnosis and management of depression in gay men – a sub-study of the primary health care project on HIV and depression*** resulted in a number of academic publications.

- The ***Private Lives 2*** Survey, funded by Movember's support to *beyondblue* and conducted by the **Australian Research Centre in Sex, Health and Society at La Trobe University** examines the health and wellbeing of same sex attracted, sex and/or gender diverse people.

- *beyondblue* commissioned the **Australian Research Centre in Sex, Health and Society,** La Trobe University, to conduct a literature review on depression and anxiety for people who are same sex attracted. The report ***Feeling Queer and Blue: A Review of the Literature on Depression and related issues among Gay, Lesbian, Bisexual and other Homosexually Active People*** can be downloaded from the *beyondblue* website: **www.beyondblue.org.au/glbti**

## Future trends and directions

Combating homophobia, transphobia, prejudice, discrimination and social exclusion of same and both sex attracted people, sex and gender diverse people will help to reduce the mental health disparity between GLBTI populations and the broader community. Social inclusion will also be more fully realised when all laws, including anti-discrimination laws, ensure equity for GLBTI populations.

The clear links between prejudice, discrimination and increased risk of depression, anxiety, suicidal ideation and problematic substance use, and *beyondblue's* role in reducing stigma and raising awareness of depression and anxiety, means there is an opportunity for *beyondblue* to continue to develop partnerships with GLBTI community organisations, government, researchers and other community stakeholders to complement existing initiatives. *beyondblue* and partners should continue to work collaboratively to improve understanding of depression and

anxiety within the GLBTI community and the impact of discrimination as a key contributing factor in the depression and anxiety in these population groups.

## Recommendations

Discrimination is preventable. Multi-sectoral strategies and actions are needed to improve social inclusiveness and health outcomes of GLBTI populations. Recommendations for a comprehensive approach include the following:

- All health, community and social service organisations are encouraged to develop policies that actively promote social inclusion for all people, including GLBTI populations. Such polices should not make assumptions about sex, gender or sexual orientation.

- Policies and programs should be implemented in schools to promote social inclusion and address bullying and homophobic/transphobic language and abuse to build safer and supportive environments for all school communities.

- Mental health services should be responsible and accountable for providing inclusive and comprehensive services for all populations. Specifically, services should ensure that service environments are welcoming and accessible for GLBTI populations, that service delivery staff have completed appropriate training, and can provide safe, non-discriminatory spaces for clients. Mental health services would benefit from training and education to improve knowledge of the impact of discrimination and to help services develop more inclusive policies, procedures and attitudes including appropriate standards of care (for example for transsexual clients undergoing physical transition to their affirmed gender).

- Specific training should be delivered to mental health services, including private practitioners, to improve standards of care for transsexual people including but not limited to the processes required to seek approval for physical transition.

- Achieving equity of health outcomes, including mental health outcomes for GLBTI populations should be built into reporting, monitoring and evaluation processes for the health service system.

- Key national data sources, including the National Mental Health Survey, should prioritise monitoring and reporting on mental health outcomes of GLBTI populations.

- Government, employers and community organisations should continue to work together to improve legislation, policies and programs to ensure the human rights of GLBTI populations, as outlined in international human rights conventions, are legally binding and upheld.

- Families, friends and communities should be accepting and supportive of individuals, particularly during the time people may be identifying their own sexuality, gender or sex diversity or identity.

- Communities should be supported with education about diversity in sex, sexuality and gender and the impact that discrimination has on mental health.

- Schools and other settings where homophobia occurs, should be supported to create positive supportive environments for all students and employees, regardless of sexual orientation, sex and/or gender.

### Appendix A – Same sex attraction, sex and gender diversity

*beyondblue* acknowledges the diversity within gay, lesbian, bisexual, trans[1] and intersex (GLBTI) populations. Not everyone will identify with this terminology as the use of an acronym oversimplifies heterogeneity within populations. The word 'populations' has been used where possible to acknowledge that personal identities do not always fit within the GLBTI acronym. Use of the term 'populations' also acknowledges that while they are often considered together, same sex attraction, sex and gender diversity are quite different.

1 Australian Psychological Society, Sexual orientation and homosexuality. Accessed on 28 November 2011,
at: **http://www.psychology.org.au**

2 Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P. & Pitts, M. (2008). *Feeling queer and blue: a review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people.* La Trobe University: Melbourne. Accessed at: **http://www.beyondblue.org.au.**

3 Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A., 2010. Writing themselves in 3. Australian Research Centre in Sex, Health and Society, La Trobe University, Monograph Series no. 78. Accessed at: **http://www.latrobe.edu.au/arcshs**

4 McNair, R., Szalacha, L.A., Hughes, T.L., 2011. *Health status, health service use, and satisfaction according to sexual identity of young Australian women.* Women's Health Issues, 21(1), pp 40-47.

5 Popay, J., Escorel, S., Hernández, M., Johnston, H., Mathieson, J., and Rispel, L., (2008). *Understanding and Tackling Social Exclusion.* Final Report to the WHO Commission on Social Determinants of Health From the Social Exclusion Knowledge Network. Accessed at: **http://www.who.int/en.**

6 Popay, et al, 2008. Cited above.

7 Australian Human Rights Commission, 2011. Addressing sexual orientation and sex and/or gender identity discrimination, consultation report. Sydney, Australia. Accessed at: **http://www.humanrights.gov.au**

8 Latitude Insights, 2011. *'in my shoes' Research: Qualitative research amongst GLBTI Australians – Final Report.*

9 Latitude Insights, 2011. Cited above.

10 Latitude Insights, 2011. Cited above.

11 Corboz et al, 2008. Cited above.

12 Hillier et al, 2010. Cited above

13 McNair et al, 2011. Cited above.

14 McNair, R., Kavanagh, A., Tong, B., 2005. *The mental health status of young adult and mid-life non-heterosexual Australian women.* Australian and New Zealand Journal of Public Health, 29(3), pp 265-271.

15 Corboz et al, 2008. Cited above.

16 Global Consortium for the Advancement of Promotion and Prevention in Mental Health. (2008). *The Melbourne charter for promoting mental health and preventing mental and behavioural disorders.* Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, Melbourne.

17 Flood, M., & Hamilton, C., 2005. *Mapping homophobia in Australia.* The Australia Institute Web paper. Accessed at: **http://www.tai.org.au/**

18 McNair et al, 2011. Cited above.

19 Corboz et al, 2008. Cited above.

20 Corboz et al, 2008. Cited above.

21 Corboz et al, 2008. Cited above.

22 Corboz et al, 2008. Cited above.

23 McNair et al, 2011. Cited above.

24 Pitts, M., Smith, A., and Mitchell, A., 2006. *Private Lives: a report on the health and wellbeing of GLBTI Australians.* Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia. Accessed at: **http://www.latrobe.edu.au/arcshs**

25 Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., Patell, S., (2007). *Tranznation: A report on the health and wellbeing of Transgender people in Australia and New Zealand.* La Trobe University: Melbourne, Australia. Accessed at: **http://www.latrobe.edu.au/arcshs**

26 Grossman, A.H., & D'Augelli, A.R., 2007. Transgender youth and life-threatening behaviours. Suicide and Life-Threatening Behaviour, 37(5), pp 527-537.

27 Couch et al, 2007. Cited above.

28 Pitts et al, 2006. Cited above

29 Birch, H., 2009. *Dementia, Lesbians and Gay Men.* Alzheimer's Australia Paper 15. Provided to beyondblue for the GLBTI Mental Health Round Table Discussion, December 2009. Available at: **http://www.alzheimers.org.au/common/files/NAT/20091000_Nat_NP_15DemLesbGay.pdf**

30 Barrett, C., 2008, *My People, a project exploring the experiences of gay, lesbian, bisexual, transgender, and intersex seniors and aged care.* Melbourne, Australia. Accessed at: **http://www.matrixguildvic.org.au/**

31 Barrett, C. 2009. *Permission to speak, determining strategies towards the development of gay, lesbian, bisexual, transgender, and intersex friendly aged care services in Victoria.* Melbourne, Australia. Accessed at: **http://www.matrixguildvic.org.au/**

[32] Birch et al, 2009. Cited above.

[33] Barrett, 2009. Cited above.

[34] Hillier et al, 2010. Cited above.

[35] Hillier et al, 2010. Cited above.

[36] Department of Health and Ageing (2007). *Research and evidence in suicide prevention.* Accessed online 14 November 2011: **http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE_research-web.pdf**

[37] VicHealth, 2007. Research Summary 3. *Ethnic and race-based discrimination as a determinant of mental health and wellbeing.* Accessed on17 November, 2011 at: **http://www.vichealth.vic.gov.au/Publications/Freedom-from-discrimination/Ethnic-and-race-based-discrimination-as-a-determinant-of-mental-health-and-wellbeing.aspx**

[38] Department of Health and Ageing (2011). *National Suicide Prevention Strategy.* Accessed online 14 July 2011: **http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/national-suicide-prevention-strategy-1**

[39] Department of Health and Ageing (2007). *A framework for prevention of suicide in Australia.* Accessed online 14 November 2011: **http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE_framework-web.pdf**

[40] Butler, M (2011). *Tackling suicide in LGBTI Community.* Accessed online 9 August 2011: **http://www.health.gov.au/internet/ministers/publishing.nsf/Content/F28091248A9E93E2CA2578D300056BB9/$File/mb075.pdf**

[41] Australian Human Rights Commission (2009). *The sex and gender diversity project: concluding paper.* Accessed online 30 September 2011: **http://www.hreoc.gov.au/genderdiversity/SFR_2009_Web.pdf**

[42] Australian Human Rights Commission (2011). *Lesbian, gay, bisexual, trans and intersex equality.* Accessed online 30 September 2011: **http://www.hreoc.gov.au/human_rights/lgbti/index.html**

[43] Australian Human Rights Commission (2011). Cited above.

[44] Australian Human Rights Commission (2011). Cited above.

[45] Australian Human Rights Commission (2009). Cited above.

[46] Australian Human Rights Commission (2011). Cited above.

[47] Australian Human Rights Commission (2011). Cited above.

[48] Australian Human Rights Commission (2011). Cited above.

[49] Human Rights and Equal Opportunity Commission (2007). *Same-sex: same entitlements: national inquiry into discrimination against people in same-sex relationships: financial and work-related entitlements and benefits.* Accessed online 30 September 2011: **http://www.humanrights.gov.au/human_rights/samesex/report/pdf/SSSE_Report.pdf**

[50] Department of Prime Minister and Cabinet (2009) *A stronger fairer Australia: national statement on social inclusion.* Department of Prime Minister and Cabinet: Canberra

[51] Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (2009). *Well proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services.* Department of Health: Melbourne.

[52] Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (2009). *Well proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services.* Department of Health: Melbourne.

[53] Smith, B., Ward, R., Mitchell, A. & Sainsbury, J. (2010). *Supporting sexual diversity in schools: a guide.* Accessed online 13 October 2011: **http://www.safeschoolscoalitionvictoria.org.au/sites/default/files/Supporting%20Sexual%20Diversity%20in%20Schools%20A%20Guide.pdf**

[54] Smith, et al, (2010). Cited above.

[55] Hillier et al, 2010. Cited above.

**Submission**


# Consolidation of Commonwealth anti-discrimination laws

# Consolidation of Commonwealth anti-discrimination laws

## *beyondblue*

*beyondblue*, the national depression and anxiety initiative, is pleased to present this submission on the consolidation of Commonwealth anti-discrimination laws to the Attorney-General's Department. In making this submission, *beyondblue* has focussed on the **relationship between discrimination and the high prevalence mental health disorders of depression and anxiety**, the impact on consumers and carers, and areas that are most relevant to our work and research findings.

*beyondblue* has conducted qualitative research on experiences of discrimination and its relationship with mental health. This has included:

- a series of focus groups with people who experience depression and anxiety and their carers (2010). The stigma and discrimination associated with mental illness was identified as a major issue in these groups.
- market research with a Gay, Lesbian, Bisexual, Trans[1] and Intersex (GLBTI) online community on the experiences of discrimination, depression and anxiety (2011).

**The issues identified through this research, and the personal experiences reported, have informed this submission.**

*beyondblue* is a national, independent, not-for-profit organisation working to address issues associated with depression and anxiety in Australia. Established in 2000, *beyondblue* is a bipartisan initiative of the Australian, State and Territory Governments, with the key goals of raising community awareness about depression and anxiety and reducing stigma associated with the illnesses. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression and anxiety, to bring together their expertise. Our **five goals** are to:

1. Increase awareness of depression and anxiety - we will increase awareness of depression and anxiety in the Australian community.

2. Reduce stigma and discrimination - we will reduce the stigma and discrimination associated with depression and anxiety in the Australian community.

3. Encourage help seeking - we will increase the proportion of people in the community with depression and anxiety who seek help.

4. Reduce impact and disability - we will reduce the impact and disability associated with depression and anxiety.

---

[1] 'Trans' is being used here as an umbrella term to cover a diverse range of experiences of sex and gender and ways of describing oneself such as trans, transgender, transsexual, genderqueer, gender questioning etc. This term has been adopted based on: Aizura, A.Z., Walsh, J., Pike, A., Ward, R., & Jak, 2010. Gender Questioning. A joint project of Trans Melbourne Gender Project, Gay and Lesbian Health Victoria & Rainbow Network Victoria. Accessed at: http://www.glhv.org.au/node/242

5. Facilitate learning, collaboration, innovation and research - we will facilitate learning, collaboration, innovation, research and information sharing to build the knowledge base of depression and anxiety and increase capacity across the Australian community.

Specific population groups that *beyondblue* targets include young people, Indigenous peoples, people from culturally and linguistically diverse backgrounds, people living in rural areas, GLBTI and older people.

## Prevalence and impact of depression and anxiety disorders

Depression, anxiety and substance use conditions are the most prevalent mental health disorders in Australia.[1]  One in three Australians will experience depression and/or anxiety at some point in their lifetime and approximately 20 per cent of all Australians will have experienced depression, anxiety or a substance use disorder in the last year.[2] People experiencing depression and/or anxiety are also more likely to have a co-morbid chronic physical illness.[3]

Mental illness is the leading cause of non-fatal disability in Australia, and it is important to note that depression and anxiety accounts for over half of this burden.[4]  Globally, the World Health Organization predicts depression to become the **leading cause of burden of disease by the year 2030**, surpassing ischaemic heart disease.[5]

Mental illness costs the community in many different ways.  There are social and service costs in terms of time and productivity lost to disability or death, and the stresses that mental illnesses place upon the people experiencing them, their carers and the community generally.  There are financial costs to the economy which results from the loss of productivity brought on by the illness, as well as expenditure by governments, health funds, and individuals associated with mental health care.  These costs are not just to the health sector but include direct and indirect costs on other portfolio areas, for example welfare and disability support costs.  **It is estimated that depression in the workforce costs the Australian society $12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover**.[6] The individual financial costs are of course not exclusively borne by those with mental illness.  It is often their carers who experience financial hardship due to lost earnings, as well as increased living and medical expenses.[7]

## Discrimination, depression and anxiety

It is well understood that **discrimination is a risk factor for poor mental health and wellbeing**.[8] Discrimination and prejudice can result in rejection by families, bullying, violence (including a fear of violence occurring and experiences of violence), restricted access to resources, and internationalisation of negative stereotypes.

Research suggests that ethnic and race-based discrimination has a negative impact on mental health, with self-reported discrimination being linked to depression, psychological distress, stress and anxiety.[9]

A number of Australian and international studies have demonstrated that prejudice, discrimination and abuse is strongly related to an increased risk of developing depression and anxiety in GLBTI populations.[10,11,12] Studies have found that non-heterosexual people face up to two times more abuse or violence (including physical, mental, sexual or emotional) than heterosexual people.[13] A fear of violence is also a strong predictor of depressive symptoms.[14]

*beyondblue's* research with GLBTI Australians suggests that[15]:

- early experiences of discriminatory attitudes and behaviours within families may be internalised, and impact on overall wellbeing and identity formation
- within workplaces, both experiences of discrimination, and a fear of discrimination, may lead to individuals feeling conflicted about openly being themselves, and seeking employment in certain industries which may provide more supportive workplace environments
- a lack of understanding and sensitivity in mainstream healthcare services is a barrier to accessing care
- the threat and expectation of discrimination is a daily occurrence for GLBTI Australians, which may manifest as stress and anxiety
- transphobia is perhaps more prevalent than other forms of discrimination and seems to stem from ignorance, naivety, misunderstanding, stereotypes and stigma
- both the immediate and longer-term impact of discrimination and its negative impact is powerful and complex.

In addition to discrimination being a risk factor for the development of depression and anxiety disorders, there are **significant levels of stigma and discrimination associated with having a mental illness**. This discrimination may be experienced in a number of contexts, including:

- employment – the stigma associated with depression and anxiety may lead to discrimination during recruitment, returning to work and promotions[16]
- housing - SANE Australia reports that nearly 90 per cent of respondents in a housing survey who had a mental illness believed that they had been discriminated against in their search for appropriate housing[17]
- health services – a fear of negative responses from health professionals may impact on help seeking[18]
- insurance - people with depression and anxiety experience difficulties when seeking all types of insurance products (e.g. life, income protection, travel, health) that are otherwise readily available to people without a history of mental illness.[19]

The relationship between discrimination, depression and anxiety highlights the need for a comprehensive and coordinated approach to address discrimination. The consolidated anti-discrimination laws provide an opportunity to help protect against experiences of discrimination, and it therefore has the potential to contribute to improved mental health and wellbeing.

# *beyondblue*'s response to the consolidation of Commonwealth anti-discrimination laws discussion paper

## Question 4: Should the duty to make reasonable adjustments in the DDA be clarified and, if so, how? Should it apply to other attributes?

Clarifying the duty to make reasonable adjustments in the Disability Discrimination Act, by including a specific standalone positive duty, will provide greater guidance to organisations regarding their responsibilities. Specific information should be provided about when reasonable adjustments need to be made, the process for undertaking this, and the limits of the obligations. Although the Victorian Equal Opportunity Act (2010) provides one example of a standalone reasonable adjustment duty, it is important to consider other alternatives to ensure the consolidated legislation clearly describes the responsibilities of duty holders.

The duty to make reasonable adjustments should be extended to all protected attributes, in order to clarify the legislation and ensure consistency. In the context of employment, this is particularly important for people with responsibilities that include caring for a family member with a disability such as mental illness. Carers of people with a mental illness face barriers to participating in employment. They are significantly less likely to participate in full and part time employment compared to those in the general community, due to their caring responsibilities.

---

**Recommendation**
1. Clarify the duty to make reasonable adjustments by including a specific standalone positive duty, and extending this to all protected attributes.

---

## Question 6: Should the prohibition against harassment cover all protected attributes? If so, how would this most clearly be expressed?

Harassment should be prohibited for all protected attributes, including disability, sexual orientation and gender identity. *beyondblue* research has demonstrated the impact that harassment, relating to sexual orientation and gender identity, may have on mental health and wellbeing:[20]

- *"The vast majority of my harassment was experienced throughout my years at high school. The schoolyard bullying was unbearable and occurred on a daily basis. There was not a single day where I was not subjected to taunts and name-calling. It was a horrible time for me and marked some of the worst depression and anxiety I have ever felt. At a time when I was still sorting out who I was and what it meant to be me, having other people bully me for my perceived sexuality was demoralising and soul-destroying. I still carry those scars today and always will…"* (25-45, Male, Gay, QLD, Regional)
- *"Sadly, sometimes it doesn't take much harassment to severely impede on someone's self-confidence and self worth. Even the smallest forms such as a sneer, a funny face or a rude remark can have a lasting effect. I know when I have held my boyfriend's hand in public and we have received unwanted remarks or gestures, it*

*stays in my head so that I am more reluctant or think twice next time I go to hold hands. I guess things like this have a way of staying engrained at the back of your mind and can lead to lasting affects of depression and anxiety. Even constantly having to second guess whether you should hold hands, kiss someone in public is a form of anxiety and is not healthy."* (18-24, Male, Gay, QLD, Metro)

Given the relationship between experiencing discrimination and harassment and an increased likelihood of developing depression and anxiety disorders, it is important that discrimination and harassment for all protected attributes is prohibited within legislation.

---

**Recommendation**

2. Prohibit discrimination and harassment against all protected attributes in the consolidated bill.

---

## Question 7: How should sexual orientation and gender identity be defined?

It is important that the definitions for sexual orientation and gender identity are inclusive. The definitions should recognise that same sex attraction, sex and gender diversity are within the normal range of human sexual orientation and characteristics. Furthermore, legislation should recognise that gender is broader than a binary construct - a person's gender identity can be defined as their *"internal sense of being male, female, something other or in between."*[21] Using binary categories to describe a person's sex is insufficient, as this kind of categorisation may exclude intersex people.

---

**Recommendation**

3. Consult with relevant representative groups to define sexual orientation, sex (including intersex) and gender diversity as protected characteristics in the consolidated legislation.

---

## Question 8: How should discrimination against a person based on the attribute of association be protected?

To ensure consistency and clarity in the consolidated bill, associated discrimination should be extended to all protected attributes, including disability, sex, gender diversity and sexual orientation.

---

**Recommendation**

4. Extend associated discrimination to all protected attributes, including disability, sex, gender diversity and sexual orientation.

---

## Question 10: Should the consolidation bill protect against intersectional discrimination? If so, how should this be covered?

It is important that the consolidation bill protects against intersectional discrimination, due to the significant impact this type of discrimination may have on wellbeing, and the difficulties in separating different forms of discrimination. The interconnections between different personal attributes and discrimination have been explored in *beyondblue* research:

- *"I believe there still is a stigma with it [mental health issues], but I struggle with my mother because she's also black. I find it hard to weigh up whether certain friends have shied away because she's black and angry, or mentally ill and angry... My mum's been refused a taxi because they thought she was another black lady that hadn't paid her bill. And of course, mum having a mental illness, went off her head. He looked at her as if to say, 'well, you're just a typical black woman'"* (Mental health carer)[22]
- *"I have always been judged as gay, first as a gay woman and now as a gay man… As I've never identified as either I find it invalidating to be judged for what I'm not. My biggest dislike is being diagnosed with a mental disorder in Gender Identity Disorder, I do not believe it is one and the result is those who do not understand my gender identity can disregard my view as deluded by simply saying I have a mental illness while pointing to the DSM-IV. This results in a medical condition that is surrounded by stigma and prejudice. For the most part people will not be disrespectful to my face… they'll wait till I leave the room."* (25-45, Transsexual, Queer, SA, Metro)[23]

Incorporating an explicit focus on intersectional discrimination in the consolidated bill may help to address the multiple forms of discrimination that an individual may experience.

| Recommendation |
| --- |
| 5. Protect against intersectional discrimination in the consolidated bill. |

## Question 11: Should the right to equality before the law be extended to sex and/or other attributes?

The right to equality before the law should be extended and applied to all protected attributes, including disability status, sexual orientation, sex diversity and gender diversity. Enabling all individuals to have the right to equality before the law may be important for symbolic purposes, by demonstrating that discrimination is unacceptable; as well as practical purposes, by helping to drive cultural change and inform policies and behaviour.

| Recommendation |
| --- |
| 6. Extend and apply the right to equality before the law to all protected attributes, including disability, sex, sexual orientation and gender diversity. |

## Question 17: Should discrimination in sport be separately covered? If so, what is the best way to do so?

It is essential that discrimination in sport be incorporated into the consolidated bill. Sporting environments are a common place in which GLBTI populations experience discrimination. This was clearly described in *beyondblue's* qualitative research with GLBTI people:
- *"I gave up my sport because I found it unwelcoming, and the prevailing climate abusive. It was the only aspect of my life where I found this… As an example of what we are faced with and how difficult it is to do something about it, one time the referee came in to check that we had taken off anything dangerous before the game e.g. jewelry and his comment was 'I don't want to see any poofy bangles'. Ironically, there*

*were 10 gay men in that room, but none of us wanted to make an issue. However, on a regular basis stuff like this, and sledging of 'faggots', 'you like it up the bum', 'poofs' makes sport a very different environment to work, school and recreational activities (I think because it is so combative and physical - full contact)."* (25-45, Male, Gay, VIC, Metro)

Symons, Sbaraglia, Hillier and Mitchell's (2010)[24] research with GLBT Victorians suggests that:

- 41.5 per cent had experienced verbal homophobia sometime during their sports involvement
- Of those experiencing verbal homophobia, 57.6 per cent reported experiencing this 'often', with 2.4 per cent experiencing homophobia 'always' within their sporting context
- 86.8 per cent of respondents indicated that the experience of discrimination had affected them in some way
- 42.7 per cent of respondents had experienced sexism at some time during their sports involvement. Transgender sport participants experienced the most sexism, followed by females and males.

Hillier, Turner and Mitchell (2005)[25] also report that only 19 per cent of young same sex attracted Australians feel safe in their sporting environment. Given the strong relationship between experiences of discrimination and abuse and the increased likelihood of developing depression and/or anxiety, it is important that the consolidated bill incorporates discrimination in sporting contexts.

---

**Recommendation**
7. Prohibit discrimination in sport in the consolidated bill.

---

## Question 18: How should the consolidation bill prohibit discriminatory requests for information?

Many people with a mental illness experience significant discrimination when applying for, and making claims against, insurance policies. [26,27] In 1993, the *Report of the National Inquiry into the Human Rights of People with Mental Illness* by the Human Rights and Equal Opportunity Commission (now Australian Human Rights Commission), revealed the systemic nature of discrimination experienced by people living with mental illness:

> *"The Inquiry was told that insurance companies frequently impose loadings, or even exclusions, on people who have (or have had) a mental illness. Witnesses considered these loadings and associated conditions were out of keeping with the true risk which their state of health implied. In particular, they considered that insurers took insufficient or no account of the type of illness, its severity, its prognosis, or its consequences for longevity or for income-earning capacity".[28]*

These findings have been confirmed by a recent national survey of people with a mental illness, conducted by *beyondblue* and the Mental Health Council of Australia.[29] This research has indicated that:

- Over 35 per cent of respondents strongly agreed that it was difficult for them to obtain any type of insurance due to them having experienced mental illness, increasing to 67 per cent for life and income protection insurance
- 45 per cent of respondents indicated their application for income protection insurance was declined due to mental illness
- 50 per cent of respondents received their insurance products with either increased premiums or exclusions specifically for mental illness.

While insurance is incorporated into the existing Disability Discrimination Act, the experiences of people with a mental illness, and their carers, suggests that the legislation needs to be strengthened to better protect the rights of people with a mental illness. Prohibiting discriminatory requests for information within the consolidation bill may lead to improved policies and practices within the insurance industry, to enable greater and fairer access to insurance for people with a mental illness.

**Recommendation**
8. Prohibit discriminatory requests for information relating to experiences of mental illness within the insurance industry.

[1] Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.

[2] Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.

[3] Clarke, D.M. & Currie, K.C. (2009). 'Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence'. *MJA Supplement, 190*, S54 - S60.

[4] Begg, S., et al. (2007). *The burden of disease and injury in Australia 2003*. Canberra: AIHW.

[5] World Health Organization (2008). *Global Burden of Disease 2004*. Switzerland: World Health Organization

[6] LaMontagne, A.D., Sanderson, K. & Cocker, F. (2010). *Estimating the economic benefits of eliminating job strain as a risk factor for depression*. Carlton: Victorian Health Promotion Foundation (VicHealth).

[7] Cummins, R.A., et al. (2007). *Australian Unity Wellbeing Index, Survey 16.1, Special Report*, in *The Wellbeing of Australians - Carer Health and Wellbeing*. Victoria: Deakin University.

[8] Global Consortium for the Advancement of Promotion and Prevention in Mental Health. (2008). *The Melbourne charter for promoting mental health and preventing mental and behavioural disorders.* Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders, Melbourne.

[9] Paradies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology, 35,* 888 – 901.

[10] Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P. & Pitts, M. (2008). *Feeling queer and blue: a review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people*. La Trobe University: Melbourne.

[11] Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J., and Mitchell, A., 2010. *Writing themselves in 3.* Australian Research Centre in Sex, Health and Society, La Trobe University, Monograph Series no. 78.

[12] McNair, R., Szalacha, L.A., Hughes, T.L., 2011. *Health status, health service use, and satisfaction according to sexual identity of young Australian women*. Women's Health Issues, 21(1), pp 40-47.

[13] McNair, R., Kavanagh, A., Tong, B., 2005. *The mental health status of young adult and mid-life non-heterosexual Australian women*. Australian and New Zealand Journal of Public Health, 29(3), pp 265-271.

[14] Corboz, J., Dowsett, G., Mitchell, A., Couch, M., Agius, P. & Pitts, M. (2008). *Feeling queer and blue: a review of the literature on depression and related issues among gay, lesbian, bisexual and other homosexually active people*. La Trobe University: Melbourne.

[15] Latitude Insights (2011). *'in my shoes' Research: Qualitative research amongst GLBTI Australians – Final Report.*

[16] Muir, K., Craig, L. & Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers*. University of New South Wales.

[17] SANE Australia (2008). *Housing and mental illness* (Research Bulletin 7). Accessed online 8 December 2011: http://www.sane.org.au/

[18] Barney, L.J., Griffiths, K.M., Christensen, H. & Jorm, A.F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health, 9* (61).

[19] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116

[20] Latitude Insights (2011). *'in my shoes' Research: Qualitative research amongst GLBTI Australians – Final Report.*

[21] Aizura, A.S., Walsh, J., Pike, A., Ward, R., & Jak (2010). Gender Questioning. Accessed online 10 January 2012: http://www.glhv.org.au/files/GQv3.pdf

[22] Muir, K., Craig, L. & Sawrikar, P. (2011). *Focus group research for beyondblue with consumers and carers*. University of New South Wales.

[23] Latitude Insights (2011). *'in my shoes' Research: Qualitative research amongst GLBTI Australians – Final Report.*

[24] Symons, C., Sbaraglia, M., Hillier, L. & Mitchell, A. (2010). *Come out to play: the sports experiences of lesbian, gay, bisexual and transgender (LGBT) people in Victoria.* Accessed online 11 January 2012: http://www.vu.edu.au/sites/default/files/Come%20Out%20To%20Play%20May%202010.pdf

[25] Hillier, L., Turner, A. & Mitchell, A. (2005). *Writing themselves in again:6 years on.*

*The 2nd national report on the sexual health & well-being of same sex attracted young people in Australia.* Accessed online 12 January 2012:
http://www.glhv.org.au/files/writing_themselves_in_again.pdf

[26] Human Rights and Equal Opportunity Commission (1993). *Report of the National Inquiry into the Human Rights of People with Mental Illness.* Accessed online 30 January 2012:
http://humanrights.gov.au/disability_rights/inquiries/mental/Volume%201%20(Text%20and%20pics).pdf

[27] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116

[28] Human Rights and Equal Opportunity Commission (1993). *Report of the National Inquiry into the Human Rights of People with Mental Illness.* Accessed online 30 January 2012:
http://humanrights.gov.au/disability_rights/inquiries/mental/Volume%201%20(Text%20and%20pics).pdf

[29] Mental Health Council of Australia & *beyondblue: the national depression initiative.* (2011). *Mental health, discrimination and insurance: A survey of consumer experiences 2011.* Accessed online 29 July 2011: http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2116