Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR MICHELLE BLANCHARD

I, Dr Michelle Blanchard, Deputy CEO of SANE Australia and Founding Director of the Anne Deveson Research Centre, of PO Box 226, South Melbourne, Victoria 3205, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Please describe your background, relevant qualifications and experience

2 I have been involved in the Australian mental health sector for the last 19 years. I am currently the Deputy CEO at SANE Australia, and the Founding Director of the Anne Deveson Research Centre, which is a SANE initiative. From 4 January to 29 April 2019, I was Acting CEO of SANE Australia while CEO Jack Heath was on sabbatical.

3 I am also a Non-Executive Director of batyr, a for-purpose preventative mental health organisation, created and driven by young people, for young people. batyr gives a voice to the elephant in the room by smashing the stigma around mental ill-health and empowering young people to reach out for support. Since 2010, batyr has reached 185,000 young Australians through schools and universities.

4 From 2016-2017, I was the National Manager of Programs and Practice at the Butterfly Foundation for Eating Disorders.

5 From 2011-2016, I was the Head of Projects and Partnerships at the Young and Well Cooperative Research Centre.

6 From 2006-2011, I held various research roles at ReachOut Australia, Australia's first online youth mental health service. I started out as a volunteer at the service in 1999, inspired by my own lived experience of mental ill-health.

7 I hold a PhD in Youth Mental Health from the University of Melbourne. I also have a Bachelor of Arts (Honours) degree with majors in Psychology and Political Science and a Graduate Diploma in Adolescent Health and Welfare from the University of Melbourne. I also hold a Diploma in Leadership and Management from BSchool.

8 Attached to this statement and marked "MB-1" is a copy of my curriculum vitae.

What is SANE Australia and what services does it provide?

9 SANE Australia was established in 1986 by Anne Deveson AO and Dr Margaret Leggatt AM as the Schizophrenia Australia Foundation. Throughout its history, SANE Australia has focused on supporting those affected by complex mental health issues and low prevalence mental disorders, such as schizophrenia, personality disorder, bipolar disorder, complex post-traumatic stress disorder and obsessive compulsive disorder. SANE does not deal with high prevalence mental disorders, such as depression and anxiety, unless they are very severe, or are co-morbid with other issues.

10 Our vision is for an Australia, where people affected by complex mental health issues live long and fulfilling lives, free of stigma and discrimination.

11 We focus our efforts on people over the age of 18. We acknowledge that there have been great advances in early intervention and care for young people, but unfortunately adults experiencing complex mental health issues continue to find it difficult to access appropriate, affordable evidence-based clinical care and psychosocial support. Furthermore, those young people who have been fortunate enough to have benefited from increased investments in youth mental health find themselves with no support when they turn 26 and need to rely on a public mental health system where there is not comparable system of care.

12 There are approximately 800,000 Australians living with severe and complex mental health issues[1]. We estimate that 200,000 of those Australians are Victorian. This represents 25% of all Australians[2]. SANE supports these people by conducting research (through the Anne Deveson Research Centre, which I explain below), through advocacy activities and the SANE Help Centre's delivery of online and telephone support services (explained further below).

13 In terms of advocacy, SANE contributes to policy formation on issues that affect the community we serve. Some key changes we would like to see include improved access to psychosocial support and better care for people experiencing complex mental health

[1] Source: Productivity Commission Issues Paper, 'The Social and Economic Benefits of Improving Mental Health', January 2019, available at https://www.pc.gov.au/inquiries/current/mental-health/issues/mental-health-issues.pdf

[2] Using the population statistics published by the ABS (Australian Demographic Statistics, Cat. no. 3101.0), and the statistics on the number of Victorians experiencing severe mental illness presented to the Victorian Parliament's Public Accounts and Estimates Committee in relation to the Victorian Budget 2019-20 (ie. 2-3% of the Victorian population), as outlined in this document: https://www.parliament.vic.gov.au/images/stories/committees/paec/2019-20_Budget_Estimates/Presentations/2019-20_BE_presentation_Mental_Health.pdf

issues in rural and regional communities. We are passionate about the need to promote life expectancy for people affected by mental illness. We believe it is unacceptable that people affected by severe mental illness die 10-20 years before their peers.

14 SANE has long been active in the area of stigma reduction. In 1997, SANE Australia's StigmaWatch program was established to promote responsible reporting of mental illness and suicide in the Australian media. We recognise that mental illness and suicide are important issues for media to cover and when reported responsibly, the media can help reduce stigma surrounding mental illness and raise awareness of suicide prevention activities. However, research shows when mental illness and suicide are reported irresponsibly, media stories can do harm.

15 The StigmaWatch team monitors and responds to reports of inaccurate or inappropriate stigmatising media portrayal of mental illness and suicide. In line with the Australian Press Council and Mindframe's reporting guidelines, StigmaWatch works with media professionals across the country to provide constructive feedback and advice on how to responsibly report stories about mental illness and suicide.

16 The team also raises the profile of media that fairly and accurately portrays mental illness and encourages the community to let them know if they see a story by a journalist who deserves congratulations. Anyone who reads, hears or sees a portrayal of mental illness or suicide in the media that they believe is inaccurate, irresponsible or offensive can report this to StigmaWatch. In the last six months, the StigmaWatch team has seen a sharp increase in the number of reports received. In the last quarter (January-March 2019) there was an 83% increase in the number of StigmaWatch reports received compared to the previous quarter.

17 SANE also delivers support services for people affected by complex mental health issues through the SANE Help Centre and Online Peer Support Forums (I explain these services in more detail below).

18 SANE also engages in a range of other initiatives, including, for example:

(a) a digital suicide prevention campaign called 'Better Off With You', which is funded by the Federal Government Department of Health; 'Better Off With You' uses a digital peer-to-peer storytelling approach featuring the real accounts of people who have experienced suicidal thoughts or ideation to engage those who are themselves contemplating taking their own lives. It aims to address

"perceived burdensomeness" which, according to Thomas Joiner's 'Interpersonal theory of suicide', is a key factor present in completed suicides[3].

(b) priority projects that focus on young adults aged 18 to 30. For example, we have recently partnered with Future Generation Global and batyr to enhance young people's access to our services, with a particular focus on young people transitioning out of youth mental health services that require specialist support during this period of transition.

19 In 2018, The Dax Centre, which uses art to create better understanding of the lived experience of those who have experienced mental health issues, trauma or psychological distress, merged with SANE Australia and became part of the SANE Australia group.

20 The Dax Centre is a leader in the use of art to raise awareness and reduce stigma towards mental health issues. Through our exhibitions and educational programs we seek to engage, inform and encourage community connections and conversations about mental health. The Dax Centre conducts educational programs for high school and university students to expand their understanding of mental health issues. We are the custodians of the Cunningham Dax Collection of art, one of only four collections of its kind in the world.

21 Addressing structural stigma and discrimination in the workplace, the area in which I have been asked to provide comment, is only one area in which action is required to ensure that all Victorians affected by complex mental health issues have the opportunity for a long and fulfilling life.

22 Aside from providing good quality evidence based clinical care and support, access to psychosocial support is critical to supporting recovery.

23 Promoting social determinants of health and addressing inequality is also essential. For example, safe and secure housing is a fundamental component for both preventing illness and promoting recovery. People affected by complex mental illness often face housing insecurity and homelessness which can cause or exacerbate their condition and impact on their ability to find and maintain employment.

24 My hope is that this Royal Commission will result in reforms that make a real difference in the lives of Victorians who are affected by severe and complex mental health issues.

[3] Joiner, T., Van Orden, K., Witte, T., Selby, E., Ribeiro, J., Lewis, R., & Rudd, M.D. (in press). Main predictions of the interpersonal-psychological theory of suicidal behavior: Empirical tests in two samples of young adults. *Journal of Abnormal Psychology*.

The Royal Commission should not under-estimate the opportunity that the implementation of the findings may have for national mental health reform.

Please describe your role and responsibilities as Deputy CEO of SANE Australia

25 As the Deputy CEO of SANE Australia, I am responsible for leading the design and implementation of SANE's research and policy agenda, including our government relations and advocacy strategy. I also oversee SANE's service delivery, including the provision of our national Help Centre and Online Peer Support Forums for people with complex mental health issues and their family, friends and colleagues.

What is the Anne Deveson Research Centre?

26 The Anne Deveson Research Centre was formally launched in November 2018. It is conducting a number of research projects that aim to drive better social outcomes for people affected by complex mental health issues. The flagship project of the Anne Deveson Research Centre is the development of the National Stigma Report Card, a multi-year partnership with the Paul Ramsay Foundation. This project will examine for the first time how Australians living with complex mental health issues experience stigma and discrimination across a range of areas, including housing, education, employment, health services, in interpersonal relationships and in media representations, to help drive positive change. A National Stigma Report Card will be created from a comprehensive survey of 7000 Australians living with complex mental illness about their experiences of stigma and discrimination. This is the largest survey of its kind conducted in Australia to date.

27 The Centre's initial focus has been on reducing stigma and discrimination. Other priorities include; ensuring that people have the right social supports as they recover from a complex mental health issue, along with issues related to housing, justice, employment and education. The Centre has a strong commitment to working in partnership with people with lived experience. We do this in a number of ways, including in paid employment, as key members of advisory boards, as co-designers of new survey tools and through participation in knowledge dissemination activities.

28 As Founding Director of the Anne Deveson Research Centre, I am responsible for leading the research team, which is based at SANE Australia. We work in partnership with the Melbourne School of Psychological Sciences at the University of Melbourne and have seconded Dr Christopher Groot to SANE three days a week to lead the National Stigma Report Card project. We also employ two Research Fellows for this project, who have honorary appointments at the University. We have also partnered with the Melbourne School of Psychological Sciences to pilot programs with the Dax

Centre to educate undergraduate psychology students and to examine how to support Help Centre workers to better support people with complex needs.

29 My role also involves facilitating partnerships, engaging with the media in relation to the public dissemination of the Centre's research and making decisions about the strategic direction of the Centre.

How does SANE Australia fit into the Victorian mental health system?

30 Based in Melbourne, SANE is a national, non-government organisation that plays a role in helping people to navigate their way through the mental health system, both in Victoria and federally. SANE Australia can be described as a navigator and a facilitator; however, it is predominantly an advocate.

How does SANE Australia help with navigating the system?

31 Through the SANE Help Centre, where we provide telephone, email and webchat support for people affected by complex mental health issues, SANE helps people navigate the mental health system. SANE receives between 12,000 and 15,000 contacts to the Help Centre every year from people affected by complex mental health issues, including family, friends and supporters of those living with complex mental health issues (some people don't like being referred to as carers, so we talk broadly about family, friends and supporters). Whilst a national organisation, given our Victorian base we disproportionally serve the needs of Victorians.

32 The contacts we receive can relate to a wide range of issues. Examples include:

(a) a person might have just received a diagnosis and may be unsure what to do next;

(b) a person might be living somewhere where they are unable to access a particular service and are looking for other options;

(c) the call might relate to advice when a person's engagement with the mental health system has not gone well and the person wants to be directed to complaint services or similar;

(d) a mental health professional requiring additional support in treating a person with a complex mental health issue.

33 SANE works to try to reduce some of the barriers to accessing services. Barriers can be everything from self-stigma, to motivation, to not knowing where to go, to not knowing what questions to ask to advocating at a systems level. For example, a person may call and not understand the difference between a psychologist and a psychiatrist, or their child has been admitted to an inpatient unit and they are not sure what supports there

might be in place for them. Or a person may call and say their psychiatrist has recommended they have an inpatient admission, but they don't want to do it. SANE's Help Centre staff do not give the person advice, but they help them to consider questions they may like to ask of their service provider, so that they will feel comfortable and confident about the decisions they are making.

34 SANE also refers people on to other psychosocial service providers, where appropriate. One of the difficulties for a service like ours is because the system is so fluid, the contact details for a service one day are not the contact details for the service another day. As a result, we tend to focus on helping people understand the types of services that might be useful (eg helping someone understand what role a psychiatrist might play in supporting their clinical needs), rather than to specific providers.

35 SANE's Online Peer Support Forums (SANE Forums) provides a safe, supportive and anonymous space for online peer support in a community setting that brings together the lived experience of individuals, families, friends and carers. The nationwide service has 15,000 members and is available 24 hours a day – monitored and moderated by mental health professionals. The forums can be accessed via saneforums.org. We had approximately 122,000 Australian users of the service in the last 12 months and 27.5% of those were from Victoria.

36 The SANE Forums has an extensive partnership program where the Forums are fully syndicated to over seventy five not-for-profit organisations, extending the reach of the program out into communities that SANE couldn't reach on their own.

37 The SANE Online Community Forums (SANE Forums) are comprised of two online communities:

(a) Lived Experience Forum: for people living with complex mental health issues – where the most commonly discussed issues are borderline personality disorder, recovery, depression, self-care, suicide prevention, anxiety disorder, relationships, medication, employment and finding help; and

(b) Carers Forum: for those supporting someone living with complex mental health issues – where the most commonly discussed issues are caring for a child, bipolar disorder, caring for a partner, relationships, caring for a parent, borderline personality disorder, caring for a sibling, schizophrenia, family and self-care.

38 SANE Australia's Peer Ambassador program has a national cohort of 91 Peer Ambassadors, 33 of which are Victorian based. SANE Peer Ambassadors are trained and supported to work alongside us in sharing their personal experience of living with, or supporting someone with a complex mental illness, to raise awareness, reduce

stigma associated with mental illness and advocate for policy and social change. Our Peer Ambassadors are frequently called upon to conduct presentations in workplaces where employers are looking to address issues like stigma and low workforce participation rates by people with mental illness. Thirty workplace presentations have been conducted in the twelve months 30 June 2018 to 30 June 2019.

39 Our Peer Ambassadors are usually invited into workplaces as part of a wider strategy to address stigma associated with help seeking and improve the employer's understanding of how they can support someone in their recovery. Employers are looking for tangible, practical strategies for how to:

(a) have difficult conversations

(b) how to recognise when someone needs further support

(c) provide appropriate support in the workplace, rather than removing someone from it.

40 The prevalent message from our Peer Ambassadors is that it's not about 'strategies' but about building a culture where people feel safe and connected to one another as people, so that when someone is struggling, it's identified very quickly and that person feels comfortable disclosing and seeking help. For a number of years, we have supported Peer Ambassadors to educate new recruits into Victoria Police through programs at the Policy Academy.

How is SANE funded?

41 SANE is funded by a range of sources, including government grants, philanthropy and individual donations. We receive federal government grants for our Online Peer Support Forums and for our StigmaWatch program. Our Help Centre, which has operated for over twenty years, is funded entirely through private donations and philanthropy.

42 SANE also has a significant partnership with the Paul Ramsay Foundation, which has provided us with a total of $5.772 million over five years for the National Stigma Report Card. The Dax Centre, which is part of the SANE Australia group, is funded by the Victorian Government and philanthropic grants.

Is structural discrimination the same as stigma? If not, how are they different?

43 Stigma contributes to structural discrimination. Stigma can be described as the attitudes that people hold about someone's experience of mental ill health. Stigma can play out in a number of ways:

(a) self-stigma, which relates to the stigma a person directs towards their own experience; and

(b) public stigma, which relates to the attitudes of the general community towards people with mental illness.

44 For example, a person's self-stigma will impact on whether or not they are going to put themselves forward for a job, a relationship or an opportunity in different environments. As someone who experienced an eating disorder in my mid-twenties and chose not to disclose this at the time, this is something I have experienced first-hand. The impact of self-stigma can be insidious.

45 Public stigma on the other hand, can shape an employer's attitude towards employing someone with a lived experience of mental illness.

46 As Hatzenbuehler and Link stated, structural stigma is the "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatised populations"[4]. The wellbeing of people with mental illness is significantly impacted by structural stigma related to mental illness.

47 Structural discrimination relates to the systems and processes that affect a person's life. An example would be where someone is overlooked for an employment opportunity because they disclose that they are living with a mental illness. The concepts of stigma and structural discrimination intersect. The presence of stigmatising attitudes informs discriminatory behaviours.

To the extent that structural discrimination encompasses environmental, institutional and attitudinal barriers, could you please explain what these barriers are?

48 Environmental barriers or cultural barriers arise in particular contexts, for example in the workplace. These types of barriers can arise in a number of ways. For example, a person with a severe mental illness may be hesitant to disclose their illness during a job interview for fear that the employer will hold a prejudice or assumption about their abilities and will not offer them a role. This idea of anticipating stigmatising attitudes or discriminatory behaviour is known as perceived stigma. This non-disclosure can be detrimental to a person once they commence the role or are trying to stay in the workforce, as it can mean that they are unable to access flexible work arrangements or reasonable adjustments that they might find helpful to remain in the workforce.

[4] Hatzenbuehler, M.L., and Link, B.G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine, 103,* 1-6.

Research conducted by SANE Australia and the Mindful Employer Program found that 38% of people surveyed did not disclose their mental illness at work[5].

49 Another example of an environmental or cultural barrier in the workplace is demonstrated in the practice of sick leave. Employees accumulate ten days sick leave per year if they are employed full-time. Entitlements reset each year and employees cannot bank their leave for when they need it. The episodic nature of mental illness may then mean that individuals need to take unpaid leave. Flexibility in how leave is accumulated and banked could facilitate retention of employees who live with mental illness.

50 Institutional barriers encompass legislative and policy challenges. For example, in relation to insurance discrimination, people with mental illness can experience difficulties obtaining travel insurance, total and permanent disability insurance and life insurance, and in some cases are simply ineligible for those types of insurance due to mental health exclusions. There is a recent report from the Victorian Human Rights and Equal Opportunity Commission which discovered frequent incidents of unlawful discrimination in relation to travel insurance.

51 This discrimination is unlawful under laws which prevent discrimination on the basis of disability. However, people with lived experience don't always see mental illness as a disability, and in fact, seeing it as a disability is quite counter to the recovery framework. I believe that it is possible to live a good life with a mental illness.

52 Attitudinal barriers within workplaces are experienced in the ways in which people may be treated when they require flexibility in the workplace, for example to accommodate medical appointments or reasonable adjustments to the way that they might work. Often the employee gets to a crisis point in the employment and ends up leaving, as they are unable to manage their health and wellbeing needs alongside their work. Some people end up under-employed, or end up working in areas that are different from those applicable to their qualifications. This can then have flow-on effects for their financial position and access to safe and secure housing.

53 The language used in workplaces can reveal attitudinal barriers. An example of attitudinal barriers are workplace wellbeing programs directed towards combatting lost productivity. These programs are often marketed to employers by encouraging them to think about the "burden" to their business of not looking after the mental health of their employees. On one level, the message is that it is bad for business if you don't support

[5] As noted in SANE Australia's 2011 submission to the Parliament of Victoria's Family and Community Development Committee, available here: https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/57th/iwppmi/Submissions/S007_SANE.pdf

the mental health and wellbeing of your workforce. However, SANE is aware from our engagement with our Peer Ambassadors that when society talks about people with mental illness as a burden, they feel that they themselves are considered a burden. Burdensomeness is a key factor in completed suicides[6].

54 The other issue with the language of "burden" is that employers can read "burden" as a potential risk to their business, and may avoid the potential risk by not employing someone living with a severe mental illness. In practice, what we see is that people who openly disclose they have a severe mental illness like a personality disorder, can find it very difficult to find employment. In fact, last week I had a conversation with one of our Peer Ambassadors who reported this to be the case for her and a number of her peers.

To what extent does structural discrimination exist in the workplace in Victoria?

55 Participation in meaningful work can promote mental health. By providing people with purpose, financial independence, connectedness and a better standard of living, employment can support both physical and mental health.

56 However, some work situations can increase the risk of, or exacerbate, mental health issues. If, for example, the culture in a workplace is stigmatising, people are faced with job insecurity or placed in high stress situations, this can create a negative workplace environment.

57 Research by SuperFriend found that 45% of working Australians experiencing mental health conditions reported experiencing stigma at work[7]. This discourages employees from disclosing their mental health conditions to employers.

58 Self-stigma is also prevalent. As Beyond Blue outlined in their 2018 study in to the experiences of members of the police and emergency service workforces, 32% of those with a diagnosed condition believed they caused a burden to those around them and 61% chose not to disclose their mental health condition to their colleagues. However, only 2% of those surveyed believed that those with mental health conditions are a burden in the workplace[8].

---

[6] Joiner, T., Van Orden, K., Witte, T., Selby, E., Ribeiro, J., Lewis, R., & Rudd, M.D. (in press). Main predictions of the interpersonal-psychological theory of suicidal behavior: Empirical tests in two samples of young adults. *Journal of Abnormal Psychology*.

[7] SuperFriend (2018). The survey was completed by 5,047 working Australians who were asked to rate their current workplace against 40 indicators of a thriving workplace, using a six-point scale

[8] Beyond Blue. (2018b). Answering the Call: The National Survey of Police and Emergency Services Mental Health. https://www.beyondblue.org.au/pesresearch

59 According to research featured in the final report of the Collaborative Partnership for Improving Work Participation, Australian employers hold more stigmatising attitudes towards those with mental health conditions, as compared to physical disabilities, as they feel that mental health issues are "unpredictable and often loosely defined". Employers felt better able to support people returning to work after a brief physical injury due to their confidence that they could access clear guidance on how to support the employee effectively (for example, with physical supports). However, once provided with useful information around how best to support those experiencing a temporary or permanent physical or psychological condition, employers were increasingly open to employing someone that is living with a mental illness. This study suggests that, if provided with clearer guidance, employers may be more willing to employ and work with people living with mental health issues.

60 People living with mental health conditions are three times as likely to be unemployed as the general population – this is among the highest ratio in the OECD. Those living with a psychological disability in Australia have the lowest participation rate (29%), and the highest unemployment rate (20%). The unemployment rate of those living with complex mental health issues is significantly higher than those with a physical disability (8%).

61 Those living with a psychological disability that are employed tend to work in 'poorer quality' jobs, with lower paid, less secure employment[9].

62 KPMG and Mental Health Australia's 2018 report suggested that realistic improvements in workplace mental health could improve workforce participation rates by 30% for those living with mental illness[10].

63 If workplaces were to embrace those living with mental health conditions through their hiring practices and internal processes, research shows that significant improvements are possible. Therefore, combating stigma in the workplace is of great importance and deserves increased attention and efforts.

64 There is currently no data that establishes the scale of structural discrimination in the workplace in Victoria as it relates to people with mental illness. This is where the National Stigma Report Card becomes important, as one of the objectives of that project

[9] OECD (2015a). Fit Mind Fit Job: From Evidence to Practice in Mental Health and Work, https://read.oecd-ilibrary.org/employment/fit-mind-fit-job_9789264228283-en#page12

[10] Mental Health Australia and KPMG. (2018). Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform, https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf

is to provide us with this data, utilising the evidence of up to 7,000 Australians living with complex mental health issues.

65 For people affected by severe and complex mental illness, structural discrimination manifests in three main ways:

(a) First, some people do not complete secondary or post-secondary education as a result of their experience of mental ill health or supporting someone with a lived experience of mental ill health, which then limits their opportunity to join the workforce.

(b) Second, some people find it difficult to enter the workforce, particularly if they disclose that they have a lived experience with a mental illness. For example, if there are gaps in a person's CV due to periods of severe ill health, they then face the choice of disclosing their illness, or not explaining the gap. Either approach may make it difficult for people to secure work. Limitations on employment as a recipient of a Disability Support Pension also make it difficult for some people to enter and remain in the workforce.

(c) Thirdly, we see issues around the episodic nature of many of these illnesses, particularly schizophrenia, personality disorder, OCD and eating disorders. The episodic nature of these illnesses can make it difficult for a person to anticipate their ill health, and in taking on a job, they may feel unsure as to how their illness will play out and affect their ability to participate in the workforce.

In your view, do employers hold assumptions about people with mental illness?

66 SANE's engagement with people experiencing mental illness and with employers suggests that many employers do hold assumptions about people with mental illness. In relation to complex mental illness, these assumptions can range from employers saying that people with complex mental illness do not exist in their workplace (for example, we have heard this from people working in professional services, financial services and the legal profession), through to employers making assumptions that people living with complex mental illness are unreliable, unpredictable, difficult to work with and that they are more likely to take time off work.

67 My experience is that, when supported well, people with mental illness can make a valuable contribution to the workplace in a variety of industries and roles.

68 In my experience, there is a real difference between how employers and the general public view high prevalence mental health issues, such as depression and anxiety, compared to severe and complex mental health issues. Many of us will have had a lived experience of depression or anxiety, or know someone who has. When it comes to more severe and complex mental health issues which are less well understood and

more stigmatised, there is still this very strong sense that you keep that quiet and don't disclose that. This is due to concerns around impact on employment status, unfair treatment in the workplace, loss of credibility, gossip or rejection[11].

69 There are few public examples of highly functioning and engaged employees with well-managed complex mental illnesses. The consequence of this is that people experiencing complex mental illness do not have the same reference point when considering how they will enter the workforce. This also contributes to the lack of understanding of and stigma associated with complex mental health issues. If you cannot see your experiences represented publicly, it is difficult to imagine how barriers can be overcome.

70 There have been high profile examples of people who have taken time out for periods of mental ill health, for example judges, members of the police force or first responders (to crisis). But, in a way, the kind of public narrative around that is "well, that's reasonable", since we assume that they, for example, have probably seen horrific things and this is a response to having seen horrific things.

71 However, conditions such as personality disorder and schizophrenia are still considered inherently different. I believe that there are two main reasons for this. First, the lack of stories in the public domain about people's lived experience of what it looks like to live with these complex illnesses. Secondly, and importantly, media representations of complex mental health issues tend to focus on the negatives. In particular, where someone accused of a violent or horrific crime has a mental illness, media coverage often involves attributing the incident to an experience of mental ill health, usually schizophrenia.

72 The more we can tell stories about people who are experiencing recovery, have had good outcomes and have received help at the right time, and who are meaningfully employed, the more we can start to break down some of that stigma and discrimination - whether it is in employment, or the health profession or other sectors. This will result in people with mental illness feeling valued and included and will support their right to social, economic and cultural participation.

What is the effect of labelling in relation to stigma?

73 In my opinion, labelling is a complex issue. For some people, labelling gives them a sense of empowerment and can validate their experience. For example, a family with a child diagnosed with autism might feel that it opens a door to support services in the community that they can access. The same thing can happen with mental illness.

[11] Brohan et al. (2012). A systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace.

However, there are also many people with lived experience who prefer not to be referred to as mentally ill.

74 Sometimes labelling can increase stigma. For example, a person presenting with a personality disorder at an emergency room for a physical injury might be told that the pain is '*all in their head*'. Examples like this came to life as we liaised with project stakeholders for recent research we conducted on this topic for the National Mental Health Commission. We have also heard from our Peer Ambassadors, and in the same research project, of doctors refraining from officially diagnosing patients, due to the stigma around conditions such as borderline personality disorder and their fear that the patient may struggle with a label that is so highly stigmatised.

Is structural discrimination different across different workforces?

75 There is currently no reliable data on how experiences of structural discrimination differ across different workforces.

76 SANE is aware of specific programs aimed at reducing stigma and discrimination in the construction, mining and legal sectors. For example, MATES in Construction, which was established in 2008 by the Australian Building and Construction Industry, aims to reduce stigma in the construction industry, in order to encourage help-seeking behaviours and reduce the high rates of suicide amongst construction workers [12]. MATES in Mining is a similar initiative, developed by the Australian mining industry, based on the same model[13].

77 The Fifth National Mental Health and Suicide Prevention Plan speaks directly to the need to reduce stigma towards people experiencing poorly understood mental illnesses within the health system, a setting in which it is known that stigma and discrimination can be higher.

Has the prevalence of structural discrimination changed over time?

78 Again, at present, there is not yet adequate data on the prevalence of structural discrimination in relation to complex mental illnesses. Attitudes in workplaces around illnesses such as depression and anxiety are starting to change as a result of many factors, including initiatives such as the Mentally Healthy Workplace Alliance and 'R U OK Day?' and workplace education strategies, as found in this report by the Queensland Mental Health Commission[14].

---

[12] MATES In Construction, http://matesinconstruction.org.au/

[13] MATES In Mining, https://www.facebook.com/matesinmining/

[14] Reducing mental health stigma in the workplace, https://www.qmhc.qld.gov.au/sites/default/files/reducing_mental_health_stigma_in_the_workplace_january_2019.pdf

79 From speaking with individuals who have been involved in SANE Australia from the beginning, from SANE's experience from contacts to our service, our Online Forum and the Peer Ambassadors, our experience is that an unintended by-product of de-stigmatising depression and anxiety is an increase in stigma towards the more complex conditions. Low prevalence disorders such as schizophrenia are seen as inherently different from common mental disorders as they do not reflect the public stories told of recovery from mild to moderate episodes of these common disorders.

What are some of the consequences of structural discrimination in the workplace for individuals?

80 One consequence of structural discrimination in the workplace is that people are not engaged in meaningful work, which can be distressing, isolating and financially disadvantageous. This can have flow-on effects for the person's family and loved ones, as the person experiencing complex mental health issues becomes more isolated and reliant on their family and loved ones for emotional, financial and psychological support.

81 Another consequence is that the community and the workforces do not benefit from the skills, experience and empathy that people with lived experience can bring to the table. In my view, that is a lost opportunity.

What are some of the consequences of structural discrimination in the workplace for family and friends of people with mental illness?

82 There can be many consequences of structural discrimination in the workplace for family and friends.

83 Based on SANE's engagement through the Helpline and the Online Peer Support Forums with the family and friends of those living with complex mental health issues, and on feedback from Peer Ambassadors that support someone living with a complex mental health issue, family and friends of people with a lived experience of mental illness can feel that they cannot talk openly about their experience in their own workplace. In that sense, they experience stigma by association. This can impact, for example, an employer's willingness to provide somebody with flexibility to work non-standard hours or work from home, which could impact a person's ability to provide the support and care that their loved one requires. It may also affect a person's ability to build relationships in their workplace, as they feel unable to disclose a part of their life that significantly impacts upon them and their lifestyle. This can also impact their own mental health and wellbeing.

84 A real difficulty for carers can be the episodic nature of mental illness. The episodic nature of illnesses, such as schizophrenia and personality disorder, is often all-consuming and requires carers to drop everything to provide support. This does not fit in

neatly with the traditional structures of paid employment, particularly where people are expected to work set hours at the workplace, and have fixed amounts of leave. For example, you may plan to be at work on time, but if you're staying at home helping someone get ready for their day, that could take longer than expected, then you're late for work. Appointment times may be available at inopportune times and difficult to coordinate. Services which are available out of hours are rare.

85 Carers who are participating in the workforce may also have to use their leave provisions to care for their loved ones. This may impact on the annual leave and sick leave entitlements. Carers may also struggle to provide evidence for their caring arrangements as in addition to providing support in clinical interactions, it is estimated that 67.7% of mental health carers' time is devoted to emotional support[15].

86 Family and friends of people living with mental illness are likely to experience financial flow-on effects of the illness. SANE is part of the Caring Fairly campaign which is led by Mind Australia. As part of that campaign, research has been conducted in partnership with the University of Queensland to review the financial security of unpaid carers. A significant issue is the fact that as mental health carers approach the end of their life, their superannuation balance is generally lower than other people in the population[16].This issue is compounded by the fact that carers are often women, and women are more likely to have other periods of career interruption and often earn less than their male counterparts[17]. The result is that they are even more financially disadvantaged than they would have otherwise been.

87 There is also a difference in the way that carers are treated in the workplace when comparing mental illness carers to physical illnesses. For example, it is common for colleagues to hold fundraisers to support people with loved ones experiencing a physical illness or for employers to provide additional leave. In my experience, no one does those things when someone's partner is diagnosed with an illness like schizophrenia. It can be incredibly lonely and isolating for carers.

---

[15] The economic value of informal mental health caring in Australia', 2017, available at: http://caringfairly.org.au/sites/default/files/pdf/The_economic_value_of_informal_care_full_report.pdf

[16] 'The economic value of informal mental health caring in Australia', 2017, available at: http://caringfairly.org.au/sites/default/files/pdf/The_economic_value_of_informal_care_full_report.pdf

[17] *'Understanding factors associated with Australian mental health carers' employment', 2018, available at:* https://www.mindaustralia.org.au/sites/default/files/Understanding_factors_associated_with_Australian_mental_health_carers_employment_technical_report.pdf

If nothing is done in this area, what are the likely impacts of structural discrimination and stigma in the workplace in relation to mental illness in the future?

88 In my opinion, as the job market becomes more competitive, people affected by complex mental health issues and their carers are likely to experience ongoing and increased disadvantage in the form of distress, isolation, a lack of agency and self-efficacy. The consequential social, economic and cultural impacts on people experiencing mental health issues and carers are likely to be enormous. By cultural impacts, I mean the impact of people being prevented from participating actively in the life of their community. As a society, we lose out on not experiencing the wonderful contributions that people with mental illness can make to public life.

89 Carers themselves are at increased risk of developing mental health difficulties of their own.

What positive steps can be taken to counter structural discrimination and stigma in the workplace, in relation to mental illness?

90 One example of a national approach to addressing mental health in the workplace is the Mentally Healthy Workplace Alliance, of which SANE Australia is a member. The Alliance is a national approach by business, community and government to encourage Australian workplaces to become mentally healthy for the benefit of the whole community and businesses, big and small. The Alliance received a commitment of $11.6m to tackle this issue in the recent Federal Budget.

91 One of the key steps that can be taken to counter structural discrimination and stigma in the workplace is to create opportunities to talk about mental illness in the workplace in a way that is inclusive of people with severe and complex mental health issues, as well as those with mild to moderate concerns.

92 In my view, it is important that employers, managers and human resources teams receive training on identifying and having conversations with employees with mental illness or that are providing care to people with mental illness, so that they can better support them. One possible initiative to build these skills is the Mental Health First Aid program, which was developed here in Australia.

93 Employers could also refine recruitment processes in order to create opportunities for people to disclose appropriate supports that they may need when entering the workforce, without fear of being stigmatised.

94 There are also opportunities at a structural level to create working arrangements that recognise the episodic nature of mental illness. For example, in the Caring Fairly campaign, one of the proposals being considered is whether there is an opportunity for

carers to access something similar to maternity leave so that their superannuation can continue to be paid while they take time out to care for a loved one that is experiencing a mental health difficulty[18]. Another option is for carers to have their personal leave rollover from year to year. This means that if they worked reliably for a year or two and then were required to take some time off to care for their loved one, they would have the flexibility to do so. Another option is allowing employees to use long service leave towards caring for somebody, if that is appropriate and necessary for them.

95 Addressing structural stigma and discrimination is an essential part of a holistic approach to ensuring that all Victorians living with a mental illness have the opportunity for a long and fulfilling life.

sign here ► MBl

print name Dr Michelle Blanchard

date 27 June 2019

[18] Submission by Caring Fairly to the Productivity Commission Inquiry into the social and economic benefits of improving mental health, available at: https://www.pc.gov.au/__data/assets/pdf_file/0006/241098/sub427-mental-health.pdf

Royal Commission into
Victoria's Mental Health System

ATTACHMENT MB-1

This is the attachment marked 'MB-1' referred to in the witness statement of Dr Michelle Blanchard dated 27 June 2019.

CURRICULUM VITAE

Dr Michelle Blanchard
BA (Hons), Grad Dip. Adol Hlth Welf, PhD. DipLeadMgt. MAICD.

CONTACT DETAILS

Mail	C/- SANE Australia, PO Box 226, South Melbourne, VIC 3205
Phone	03 9682 5933
Email	michelle.blanchard@sane.org

EMPLOYMENT HISTORY

SANE Australia **2017 -**

SANE Australia is a national mental health charity working to make a real difference in the lives of people affected by complex mental health issues through support, research and advocacy.

Acting CEO **January to April 2019**

Appointed Acting CEO while the CEO took a four-month sabbatical.

Deputy CEO **July 2018 onwards**

Responsible for leading the design and implementation of SANE's research and policy agenda, including our government relations and advocacy strategy. Have oversight for SANE's service delivery, including the provision of the SANE Help Centre and Online Peer Support Forums for people with complex mental health issues and their loved ones.

Founding Director, Anne Deveson Research Centre **July 2018 onwards**

Responsible for establishing this non-profit based research centre to drive better social outcomes for people affected by complex mental health issues, including oversight for the development of the National Stigma Report Card, a multi-year partnership with the Paul Ramsay Foundation.

General Manager – Research, Policy and Programs **April 2017 – June 2018**

Responsible for leading the design and implementation of SANE's research and policy agenda, including our government relations and advocacy strategy. Had oversight for SANE's service delivery, including the provision of a National Helpline and Online Peer Support Forums for people with complex mental health issues and their loved ones.

The Butterfly Foundation for Eating Disorders **2016 - 2017**

The Butterfly Foundation is Australia's national charity supporting people affected by eating disorders.

National Manager, Programs and Practice

Led Butterfly's clinical and support services, and managed Butterfly's contribution to the eating disorders knowledge base, informing and influencing Butterfly's advocacy, awareness campaigns and communication. Ensured that the clinical and support services were evidence based and/or evidence generating, professionally delivered, ethical and safe. Reported to the CEO and was part of the Senior Leadership Team. The role was a maternity leave replacement to 31 March 2017. Prepared grant applications for funding in excess of $1 million.

Young and Well Cooperative Research Centre **2011 – 2016**

Head of Projects and Partnerships **February 2012 – June 2016**

Identified, developed and facilitated strategic partnerships to ensure that the Young and Well CRC's research agenda was delivered in a way that maximised benefits for young people's mental health and wellbeing. This included ensuring that all Young and Well CRC participants were able to contribute to the CRC in a way that made the best use of their expertise and resources.

Youth and Sector Engagement Manager **July 2011 – February 2012**

Overall responsibility for the development and management of the CRC's Education, Training and Professional Development and Youth Participation Programs. Developed, implemented and coordinated the youth and sector engagement agenda for the CRC. Was also responsible for building and maintaining relationships with end-user organisations to facilitate their engagement with the CRC's activities and to ensure that the outputs of the CRC could be integrated into policy and practice. I was part of the Young and Well CRC Executive Team, reported directly to the CEO and managed a small team including a Youth Participation Officer and a Research Assistant. Established the Young and Well CRC's Youth Participation programs, including the Youth Brains Trust who guide the CRC's research.

Communications and Partnership Manager **January 2011- June 2011**

Responsible for managing relationships with partners during the start-up phase of the Young and Well CRC, with a particular focus on working with legal counsel to negotiate the successful execution of agreements with the original 63 partners in the CRC. Other tasks in this set up phase included facilitating the CRC's engagement with social media, developing the Young and Well Network and supervision of a Project Officer and Research Assistant.

ReachOut Australia **2006 –2011**

Senior Research Officer 2010
Project managed the successful bid to establish the Young and Well CRC, resulting in a cash investment from the Commonwealth Government of $27m over five years. Also undertook strategic research projects, including the evaluation of the ReachOut Professionals service.

Research Officer/Research Project Manager 2006-2010
Responsible for managing research projects and collaborations to explore the role of technologies in promoting wellbeing for young people. Utilising both qualitative and quantitative research methods to conduct research investigating young people's use of information communication technology, civic engagement, mental health and wellbeing.

City of Yarra 2005 - 2006

Youth Participation Officer (part-time) 2005-2006
Responsible for developing and executing a youth participation strategy to support young public housing residents to establish 'youth reference groups' at each of the high rise public housing estates in Yarra, through which young people advocated for their needs and the needs of their communities.

Office for Youth, Department for Victorian Communities 2004 - 2005

Project Officer, youthcentral 2006
Managed the development of a Schoolies Week sub-site within youthcentral, the Victorian Government's online youth participation and employment initiative. Provided information and referral support to young people on career and employment related matters and supported the research and evaluation activities of the project.

Project Officer, youthcentral 2004 - 2005
Managed administration and logistics processes for 'The Write Stuff' competition, which provided training and employment opportunities for young writers. The role included developing procedures for the assessment of entries, travel and accommodation arrangements, purchases, equipment hire, insurance for finalists and stakeholder liaison, as well as providing briefings and support to the young people participating in the project.

Project Officer, Eureka 150 2004
Managed a state-wide team of young people whose role was to bring about greater awareness of the legacy of the Eureka Stockade. The role included liaising with stakeholders across state and local government, community and cultural organisations and developing an orientation program to equip the participants for their role.

Australian Youth Research Centre 2004 - 2005

Research Assistant 2004-2005
Responsible for preparing an annotated bibliography on the voices of young people with significant mental health difficulties on the issue of engagement with schooling, and compiling case studies on the ways in which local government's promote young people's civic engagement. The former was published in the Australian Journal of Guidance and Counselling.

Paris First Partners 2005

Research Assistant 2005-2006
Assisted with the establishment of performance measures to assess the reach and effectiveness of the Department for Victorian Communities' online youth participation and employment program, youthcentral.

Student Support Services, University of Melbourne 2003 - 2004

Graduate Employment Assistant 2004
Responsible for supporting graduate recruitment activities and co-ordinating vacation recruitment activities on campus, including Careers Fairs, information sessions, direct mail-outs to students and campus interviews. Liaised with employers to market Careers & Employment Services and advised them how best to target their recruitment campaigns.

Student Services Assistant 2003
Provided information and referrals to students regarding counselling, financial aid, housing and careers.

ACADEMIC QUALIFICATIONS

Diploma of Leadership and Management, BSchool. 2015 - 2016
Completed subjects in workforce and operational planning, managing risk, negotiating personal work priorities and professional development, designing and utilising performance management systems, developing and using emotional intelligence and building and sustaining an innovative work environment.

Doctor of Philosophy. University of Melbourne. 2008 - 2011
Thesis title: *Navigating the Digital Disconnect: Understanding the Use of Information Communication*

Technologies by the Youth Health Workforce to Improve Young People's Mental Health and Wellbeing.
Graduate Diploma in Adolescent Health and Welfare, University of Melbourne. 2004
First class honours in final year.
Bachelor of Arts (Honours), University of Melbourne 2003
First Class Honours in Political Science. Thesis title: *101 Perspectives: Rethinking Young People's Participation in Political Action.* Final thesis received First class honours.
Bachelor of Arts (Psychology and Political Science), University of Melbourne 2000 - 2002
Included the completion of an internship in the Victorian Parliament in my final year.

ACADEMIC APPOINTMENTS

School of Psychological Sciences, University of Melbourne 2019 -

Senior Research Fellow (Honorary) January 2019 -
Launched a partnership with the Melbourne School of Psychological Sciences (MSPS). As part of the agreement, researchers from MSPS will work with Anne Deveson Research Centre (ADRC) staff on the Centre's flagship initiative, the National Stigma Report Card.

Centre for Youth Mental Health, University of Melbourne 2012 - 2016

The Centre for Youth Mental Health is the academic research centre associated with Orygen, the National Centre of Excellence in Youth Mental Health. The Centre's work focuses on understanding the biological, psychological and social factors that influence onset, remission and relapse of mental illnesses in young people.

Research Fellow (Honorary) 2012 - 2016
This was an honorary appointment, focused on growing the evidence for the role of technologies in supporting young people's mental health and wellbeing and was a joint appointment with the Young and Well CRC.

TOP TEN PUBLICATIONS

1. Burns, J., Davenport, T., Ricci, C., Birrell, E., Blanchard, M. & Hickie, I. (2016). It's one 'smart' solution: Using new and emerging technologies to support the mental health and wellbeing of young men. Developing Practice: The Child, Youth and Family Work Journal. Issue 40.
2. Carrotte, E and Blanchard, M. (2018). Understanding the Experiences of Australians Living with Personality Disorder. National Mental Health Commission. Sydney.
3. Blanchard, M., Morris, J., Birrell, E., Stephens-Reicher, J., Third, A. & Burns, J. (2015). National Young People and Asthma Survey: Issues And Opportunities In Supporting The Health And Wellbeing Of Young Australians Living With Asthma. Young and Well CRC, Melbourne.
4. Burns, JM, Davenport, TA, Christensen, H, Luscombe, GM, Mendoza, JA, Bresnan, A, Blanchard, ME & Hickie, IB. (2013). Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing. Findings from the first Young and Well National Survey. Young and Well CRC, Melbourne.
5. Blanchard, M., Burns, J., and Hosie, A., (2013). Embracing technologies to improve wellbeing for young people: An Australian view of evidence and policy implications. Commonwealth Health Partnerships 2013. p127-132.
6. Blanchard, M., Herrman, H., Frere, M and Burns, J. (2012) Attitudes informing the use of technologies by the youth health workforce to improve young people's wellbeing: Understanding the nature of the "digital disconnect." Youth Studies Australia. Youth Studies Australia. Vol 31, No 1, Suppl 1:S14-24.
7. Collin, P., Rahilly, K., Stephens-Reicher, J., Blanchard, M., Herrman, H., Burns, J. (2012). Complex Connections: Meaningful youth participation for mental health promotion. Youth Studies Australia. Vol 31, No 1, Suppl 1: S36-47.
8. Collin, P, Metcalf, A, Stephens-Reicher, J, Blanchard, M, Herrman, H, Rahilly, K & Burns, J. (2011). The role of online services for promoting help-seeking in young people: A case study of ReachOut.com. Advances in Mental Health, Volume 10 Issue 1.
9. Stephens-Reicher, J., Metcalf, A., Blanchard, M., Mangan, C. & Burns, J. (2010). Reaching the Hard to Reach: How Information Communications Technology (ICT) can reach young people at greater risk of mental health difficulties. Australasian Psychiatry. Vol 19, Supplement 1
10. Blanchard, M., Metcalf, A., Degney, J., Herrman, H. & Burns, J. (2008) Rethinking the Digital Divide: Findings from a Victorian Study of Marginalised Young People's Information Communication Technology (ICT) Use. Youth Studies Australia, 27, 35-42.