Submission: National Stigma and Discrimination Reduction Strategy

1 February 2023

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest community-controlled health service providers for people living with HIV, and the lesbian, gay, bisexual, trans and gender diverse, intersex and queer (LGBTIQ+) communities. Thorne Harbour Health primarily services Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTIQ+ people and all people living with HIV.

Thorne Harbour Health provides the following services to support the mental health of LGBTIQ+ people:

- Counselling services for people affected by or at risk of HIV (many of whom in Victoria are men who have sex with men) as well as people from LGBTIQ+ communities.
- Alcohol and drug counselling, care coordination and therapeutic group services for LGBTIQ+ people and people living with HIV.
- Family/intimate partner violence programs for LGBTIQ+ people and people living with HIV.
- LGBTI inclusive general practice and specialist care for people living with HIV or hepatitis C, and bulk billing general practice services to the trans and gender diverse community.
- The Positive Living Centre, a psychosocial support program for people living with HIV.
- Housing Plus, a state-wide program supporting people living with HIV who are homeless or at risk of homelessness

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Contents

Summary of Recommendations 3

1. Feasibility: Are the actions achievable in the recommended timeframe and allocated to the correct responsible party/parties? Is there a readiness for change? 5

2. Enablers: What might support the actions and/or assist the work needed to implement the change? 6

3. Barriers: What might slow down or prevent the gaining of support for the actions, or their implementation? 11

4. Effectiveness: Will the actions lead to the changes we want to see? Are there any potential unintended consequences? 15

5. Anything missing: Are there any critical issues or actions to address stigma and discrimination that are not referenced or sufficiently prioritised in the Draft Strategy? ... 17

Summary of Recommendations

Recommendations: Enablers

1. Ensure LGBTIQ+ community-controlled organisations are consulted regarding the impact of stigma and how such organisations consult and treat the compounding layers of not only mental health stigma but also stigma associated with minority or intersectional status suffered by the communities they serve. Any such consultations with these organisations should have the goal of developing models of best practice that are then provided for mainstream service providers to adopt.

2. Ensure that the data collection of LGBTIQ+ persons seeking mental health treatment across Australia is appropriately disaggregated and inclusive.

3. Ensure that Australia attracts a diverse lived experience workforce across the entire service delivery continuum by encouraging state governments to initiate or further develop financial incentives offered to diverse communities in commencing relevant training or accreditations.

4. Ensure that any and all health promotion materials developed and disseminated associated with the delivery of the strategy is sufficiently targeted towards priority populations such as the LGBTIQ+ communities.

5. To increase media literacy in mental health by strengthening existing media guidelines to ensure the accurate, fair and just portrayal of persons with ill mental health and to bolster this with improved accountability mechanisms. Any such guidelines must be consulted by relevant stakeholders from diverse backgrounds.

Recommendations: Barriers

1. Encourage state government to provide sufficient funding for community-controlled organisations to provide specialist mental health care to priority populations in lessening mental health stigma in their respective communities.

2. Increase mental health literacy initiatives available to the general public. Any such initiatives

must acknowledge priority populations such as the LGBTIQ+ populations so as to afford community members with adequate risk awareness.

3. To ensure that any and all training or educative materials delivered to relevant stakeholders remains uniform and is not tailored or amended to fit specific organisational, institutional or individual values, beliefs or ideology.

4. To ensure that communities of intersecting minority status receive adequate engagement to develop and evaluate the success of any future iterations of the strategy.

Recommendations: Effectiveness

1. To ensure that any prospective strategy is cognisant of, or ideally expressly mentions, the impact the strategy may have in enlivening public debates and negative media attention regarding LGBTIQ+ persons. This is especially germane to that of the trans and gender diverse population, given this population is currently subject to a variety of targeted negative media narratives whilst remaining a population that suffers disproportionately worse mental health outcomes.

Recommendations: Anything missing

1. For any prospective strategy to consider, or ideally expressly include, LGBTIQ+ communities within appropriate actions where other priority populations are mentioned.

2. For any prospective strategy to expressly mention the beneficence of community-controlled organisations in tackling stigma and discrimination by priority populations, and where appropriate, refer to them in relevant actions.

3. For any prospective strategy to expressly include quotas within any and all advisory committees or boards so as ensure appropriate diversity is consulted and reflected.

4. To undertake a significant analysis, or fund research into available and appropriate measurements of stigma that can be attached to the strategy in forming appropriate identifiable and progressive benchmarks.

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1. **Feasibility: Are the actions achievable in the recommended timeframe and allocated to the correct responsible party/parties? Is there a readiness for change?**

At first glance, yes, the timelines within the draft strategy appear achievable. However, timelines cannot and should not be considered when an entire prospective reform may not be feasible in the first place (see ‘3. Barriers’ below).

Additionally, with respect to the query pertaining to a ‘readiness for change’, any answer must be caveated by the fundamental concepts of adequate resourcing, capacity and capability of relevant workforces to facilitate changes espoused within any prospective framework.

Thorne Harbour Health is only in a position to provide a perspective as to whether there is a readiness for change from the context of LGBTIQ+ community-controlled services. For instance, the readiness for change is particularly germane to those working within the community health sector who overly rely on short-term contracts to allow better engagement with any reform process. If there is no consistency in staffing or employment stability to retain and increase staff in the implementation of changes, the recruiting and on-boarding processes can significantly delay the delivery of recommended timeframe. The section on ‘barriers’ below will further elaborate this point.

2. **Enablers: What might support the actions and/or assist the work needed to implement the change?**

THH submits that the following will support the work needed to implement any and all changes as it pertains to implementing a National Stigma and Discrimination Reduction Strategy:

(a) Community and inter-sectoral industry consultations

Active, sustained, consistent and ongoing consultations with priority populations regarding mental health stigma and stigma reduction initiatives. From Thorne Harbour Health's perspective, such consultations must be trauma and violence-informed and employ appropriate and de-pathologising language. Priority populations such as the LGBTIQ+ individuals must be actively consulted on an ongoing basis as often people within these communities often have a lifelong experience of being discriminated in the form of marginalisation, stigmatisation, abuse or subject to harassment, thus presenting as integral population to consult in determining how to reduce such discrimination across society.

Similarly, the Commission must facilitate flexibility in relevant persons providing feedback. In this regard, the Commission should offer a wide suite of options for those who wish to participate so as to maximise available datasets. The forum of consultations could include, but is not limited to, those that are held in-person, virtually, assisted by software (Mentimeter, Miro etc), written or online surveys, and formal submissions.

(b) Community-controlled service provider consultations

Active and sustained consultation with LGBTIQ+ community-controlled service providers to better understand the impact of de-stigmatised and de-pathologised language used in service delivery. It must be recognised by the Commission that community-controlled organisations possess expertise in dealing with particular population groups, and therefore have knowledge that can be shared to mainstream services so as to elevate their service delivery to standards that are culturally safe.

As part of these consultations should be inquiries regarding resourcing and funding, determining how to best support these organisations to best provide their care to priority populations.

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(c) Data and evaluation

As LGBTIQ+ persons are not currently part of the Australian census, perhaps the most salient enabler would be data collection mechanisms that actually collect data on this priority population. It begs the question of how effective, meaningful policy in reducing stigma will be manifested when there is a complete lacunae for policy makers to interpret, analyse, implement and integrate.

Additionally, inclusivity regarding data collection across the public health system are additional considerations any future strategy should consider in reducing stigma. Here, inclusivity should extend to providing consumers the ability to self-identify their sexuality or gender expression, providing service providers the ability to tailor care and tackle any discrimination or stigma that may amplify one's mental health condition(s) whilst also providing more comprehensive data that identifies trends and patterns within particular demographics.

Lastly, any and all data collection initiatives must be appropriately disaggregated and not represent the LGBTIQ+ communities as a homogenous group.

(d) Attracting lived experience diverse workforce

By attracting a diverse lived experience workforce, such staff involved in the service provision continuum can serve to influence the reduction of stigma within their individual workplaces, and challenge norms associated with those, for example, who have lived experience and are from culturally and linguistically diverse (CALD) and other diverse backgrounds.

An example of how to manifest this enabler could take the form of the government enacting a series of scholarships and/or other appropriate incentives to attract lived experience workforce. Such incentives should not just be limited to clinical service staff, rather be inclusive of peer workers (I.e. 2.3e) and any and all staff involved or associated with the mainstream mental health service delivery continuum.

(e) Nationally coordinated responses

Upon the establishment of any prospective strategy, for the Commission to lead a nationally

coordinated advocative response in developing, implementing and integrating uniform legislative, policy or regulative change across all states and territories regarding any stigma-reduction-related initiatives in line with the goals of the Strategy. As health remains a state jurisdictional mandate, a nationally coordinated response must be led by the Commission so as to inform, influence and direct states towards appropriate reforms in reducing stigma in many facets across society.

(f) Multi-platform media health promotion to diverse communities

A multi-platform media health promotion related initiatives guided by expertise of community-controlled service delivery organisations, given their expertise and knowledge in best practice in engaging with priority populations. Any such media should ideally focus on improved engagement with young persons, especially those from CALD, Aboriginal or Torres Strait Islanders, LGBTIQ+, and other priority groups.

Importantly, acknowledging that loneliness is an exacerbating factor that leads to poor mental health and self-stigma of mental illness, such media initiatives must seek to penetrate any communication barriers suffered by those who are currently suffering loneliness by engaging individuals prone to loneliness via a multitude of means.

(g) Media and community literacy and awareness

Community education and awareness should be a central tenant of this strategy so as to improve knowledge of mental health amongst the community to reduce stigma and associated discrimination. Improved literacy will allow members of the public to better understand mental health that will entail the challenging of unhelpful, stigmatising and de-humanising pre-conceived notions of ill mental health.

Examples of effective and successful education can assist in counteracting an individual's belief that they are unworthy of others time or care whilst in times of crisis, or, in the context of employment, education can operate to alter other's perceptions of a person's ability to perform work assigned them despite having lived experience of poor mental health.

Additionally, those in the media should be provided improved guidance as to the accurate, fair and just portrayal of those living with poor mental health so as to facilitate a better, albeit

indirect, understanding of mental health by the general public. This would manifest in examples such as modelling and the utilisation of appropriate language when discussing poor mental health.

(h) Lived experience representation

Exposure to those with lived experience is an effective and cost-effective method of lessening mental health stigma in members of the community, especially in the absence of any friends, family or acquaintances who have historically experienced or are contemporaneously experiencing poor mental health. Further representation of those with lived experience from diverse backgrounds across multiple sectors such as government, media and sport should represent a salient enabler to develop and foster a narrative of anti-stigma across wider society.

Recommendations

1. Ensure LGBTIQ+ community-controlled organisations are consulted regarding the impact of stigma and how such organisations consult and treat the compounding layers of not only mental health stigma but also stigma associated with minority or intersectional status suffered by the communities they serve. Any such consultations with these organisations should have the goal of developing models of best practice that are then provided for mainstream service providers to adopt.

2. Ensure that the data collection of LGBTIQ+ persons seeking mental health treatment across Australia is appropriately disaggregated and inclusive.

3. Ensure that Australia attracts a diverse lived experience workforce across the entire service delivery continuum by encouraging state governments to initiate or further develop financial incentives offered to diverse communities in commencing relevant training or accreditations.

4. Ensure that any and all health promotion materials developed and disseminated associated with the delivery of the strategy is sufficiently targeted towards priority populations such as the LGBTIQ+ communities.

5. To increase media literacy in mental health by strengthening existing media guidelines to ensure the accurate, fair and just portrayal of persons with ill mental health and to bolster this

with improved accountability mechanisms. Any such guidelines must be consulted by relevant stakeholders from diverse backgrounds.

3. Barriers: What might slow down or prevent the gaining of support for the actions, or their implementation?

THH submits the following foreseeable barriers:

(a) Lack of appropriate resourcing and funding of community health organisations resulting in reduced or limited capacity of staff and organisations to undertake and execute particular activities related to prospective reforms. In order to not encounter a retardation of gaining of support for the actions, the government must address budgetary spending priorities by shifting its lens from that of expenses to that of investment by bolstering preventative strategies.

(b) Lack of capacity, ability or interest of those with lived experience to participate in any consultations associated with the reform

(c) Lack of parliamentary support in the form of enacting or updating legislation or regulations enshrines anti-discrimination of mental health and reflects support of stigma-reduction initiatives.

(d) Inadequate governmental engagement with all sections of community and industry

(e) Lack of mental health literacy or awareness amongst the general public to become effectively involved in any reform processes.

(f) Inefficiency of parliament and bureaucratic impasses associated with passing amendments or introducing novel legislation that will enshrine relevant stigma-reducing initiatives.

  i. For example, human rights-related amendments remain a vexed issue in Australian parliament, especially in the absence of any national human rights act. This could serve so as to dramatically slow any parliamentary support in passing legislation that could act to reduce stigma. (I.e. 2.1e)

(g) Lack of institutional or organisational support in the form of enacting or updating policy that enshrines anti-discrimination of mental health and reflects support of stigma-

reduction initiatives

(h) Pushback from particular groups, sectors or institutions regarding any and all changes lobbied by the NMHC

i. Pushback from particular religious education institutions regarding reforms of policies, procedures and practice that may be centred on inclusion. Any such amendments may mention LGBTIQ+ persons due to their identification as a priority population, which may lead to pushback in effecting any meaningful reform, or at best, create inconsistencies across educational settings and institutions. (i.e. 2.7c)

ii. Acquiescence of conservative media corporations not affiliated with any governmental funding or support regarding imposition of quotas on persons with lived experience (i.e. 3.2b)

iii. Tech companies would be very unlikely to agree to further moderation, especially with recent cuts to companies including Meta and Twitter, and historical pushback from government proposed legislation seeking to impose more burdensome regulation on such companies. (i.e. 3.2f)

iv. Facilitating religious educational institutions' staff to attend any training that would, on assumption, promote inclusion and anti-discrimination of all persons living in Australia, including LGBTIQ+ individuals. It would be a foreseeable problem to get staff of such institutions attend, or at best, having them attend but having to modify the training which would create inconsistencies in the training delivered across educational settings and institutions. (i.e. for educational settings, see 2.7b – f; for institutions, see 3.1b)

v. Elimination of seclusion and or restraints from service providers who often deal with violent patients (i.e. 2.1a)

(i) Facilitating arrangements between peak bodies may result in a stalemate due to irreconcilable differences, noting that there may be distinct differing of values of

organisations that may significantly delay implementation, especially if in the form of a legally binding contract.

(j) Fragmentation and inconsistencies of the roll-out of reforms across Australian states due to the political makeup of state parliaments and associated willingness to pass such reforms, especially with respect to LGBTIQ+ persons, noting that LGBTIQ+ persons and their rights unfortunately remain a consistent and highly polarised issue.

(k) Intersection or overlap of federal and state jurisdictions may delay perspective reforms

(l) The significance of the reform that the NMHC seeks to pass regarding the NDIS may prove extremely difficult, thereby creating a foreseeable delay (i.e. changing from the core tenant of permanency of an illness to include episodic mental illnesses)

(m) Hesitancy of CALD communities of engaging in public discussion of mental health, noting that this topic is especially sensitive within particular cultural groups (i.e. 3.2h)

(n) Hesitancy of the LGBTIQ+ communities, especially older members of the community, in engaging with particular areas of reform due aversion of engaging with authoritative bodies due to historical persecution from state-based institutions.

(o) Any disingenuous or negative media reporting on poor mental health is likely to stoke unnecessary pushback of any future strategy (discussed further below) and promulgate narratives that are unhelpful towards the strategy's success.

Recommendations

1. Encourage state government to provide sufficient funding of community-controlled organisations to provide specialist mental health care to priority populations in lessening mental health stigma in their respective communities.

2. Increase mental health literacy initiatives available to the general public. Any such initiatives must acknowledge priority populations such as the LGBTIQ+ populations so as to afford community members with adequate risk awareness.

3. To ensure that any and all training or educative materials delivered to relevant stakeholders remains uniform and is not tailored or amended to fit specific organisational, institutional or individual values, beliefs or ideology.

4. To ensure that communities of intersecting minority status receive adequate engagement to develop and evaluate the success of any future iterations of the strategy.

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4. Effectiveness: Will the actions lead to the changes we want to see? Are there any potential unintended consequences?

Will the actions lead to the changes we want to see?

As a premise, there is no 'magic bullet' to completely eradicate stigma from Australian society. Any and all effective change regarding the reduction in stigma will require structural intervention, systemic and institutional change, and ongoing and consistent commitment from government to conduct periodic evaluations to meaningfully dismantle shame narratives.

Are there any potential unintended consequences?

Regarding the first question and Priority 2 with reducing structural stigma and discrimination, community-controlled organisations must form a key stakeholder in engaging with any reform initiative and manifesting transformational and systemic change within mental health services across all jurisdictions. Any strategy must recognise and provide associated funding towards community-controlled service providers given their relevant expertise for caring for priority populations that have accordingly have been found to engender better health outcomes compared to their mainstream counterparts and that are adept in addressing and navigation issues pertaining to stigma and discrimination of particular populations and sub-populations.

Specifically with respect to Priority 3 with respect to reducing public stigma and Priority 4 regarding the reduction of self-stigma, community-controlled organisations have an especial ability of production health promotion materials for particular populations and must be consulted in order to ensure the most efficacious materials to reduce stigma are disseminated to priority populations.

THH submits that there may be a series of unintended consequences in enacting these reforms, specifically as it pertains to the LGBTIQ+ communities:

(a) The potential re-traumatising of mental health issues of those with lived experience.

(b) Potential victimisation of people with mental health challenges.

(b) Enlivening of parliamentary debates or media attention regarding potential reforms that may subject particularly vulnerable communities to vitriol, ridicule and abuse. For example,

imposition of changes of policies, procedures and practice regarding mental health would likely create pushback from certain religious educational institutions. This should remain a salient point for consideration as LGBTIQ+ persons have been consistently identified as a priority population as it pertains to suffering disproportionately poorer mental health outcomes.

For example, in recent years, the LGBTIQ+ communities have experienced and been subjected to hateful and unnecessary vitriol in debate over, including but not limited to:

- Safe schools
- Marriage equality
- The Victorian *Change or Suppression (Conversion) Practice Prohibition Bill 2020* and *Act 2022*
- The Federal *Religious Discrimination Bill 2022*
- The Victorian *Equal Opportunity (Religious Exceptions) Bill 2021* and *Act 2022*
- Trans and gender diverse rights and inclusion in sport
- Northern Territory's amendment to the *Antidiscrimination Act*

(d) Should the strategy be successful, there would be a likelihood that this would foster better help-seeking behaviours from the general public. This, in effect, would lead to an increased demand for service without adequate access causing additional burden on services and people seeking support.

Recommendations

1. To ensure that any prospective strategy is cognisant of, or ideally expressly mentions, the impact the strategy may have in enlivening public debates and negative media attention regarding LGBTIQ+ persons. This is especially germane to that of the trans and gender diverse population, given this population is currently subject to a variety of targeted negative media narratives whilst remaining a population that suffers disproportionately worse mental health outcomes.

5. Anything missing: Are there any critical issues or actions to address stigma and discrimination that are not referenced or sufficiently prioritised in the Draft Strategy?

(a) Limited express inclusion of 'LGBTIQ+' or the LGBTIQ+ communities within the actions

It should be noted that within the actions 'LGBTIQA+' is only mentioned once in the actions, despite other priority populations being mentioned multiple times.

For example, CALD has a significant focus in all the actions, but seldom is LGBTIQ+ mentioned. Given that academic literature has consistently demonstrated that LGBTIQ+ individuals disproportionately suffer poorer mental health outcomes compared to other cohorts in society, this must be reflected in this strategy's actions and sit parallel to other priority populations. Similarly, given the multiplicity of areas of self-stigma suffered by these communities, it is essential the strategy reflects that self-stigma by virtue of one's sexual orientation, gender expression or innate sex characteristics may reinforce self-stigma associated with poorer mental health and *vice versa.*

For example, under action 2.1b seeking to:

> "*[r]eview existing cultural competence/safety frameworks relating to Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse (CALD) backgrounds. Resources should explore barriers to implementation and provide support for adoption".*

Here, there is an express absence of the inclusion of LGBTIQ+-related frameworks. As the LGBTIQ+ population has been identified priority as it pertains to mental health, this demands an express inclusion of this community within this particular action.

Similarly, specific community media must be expanded to what is input within the current set of actions. For example, the actions note the use of CALD radio, however this should further include LGBTIQ+ radio stations, noting the prevalence and community engagement with JOY94.5 (i.e. 3.2h).

Additionally, and perhaps most pertinently from the perspective of THH, discrimination and stigma associated with one's sexuality, gender identity or innate sex characteristics is often the

antecedent and is reinforcing of poorer mental health outcomes, and as a corollary, the manifestation of mental health stigma. In this regard, any prospective strategy must acknowledge the impact of discrimination and stigma associated with one's sexual orientation, gender expression or innate sex characteristics that often engenders poor mental health and mental health stigma.

For example, with respect to action 4a regarding conducting research into the prevalence and experience of self-stigma, this should extend to the LGBTIQ+ populations given the interrelated often antecedent issues of gender- or sexuality-based stigma with mental health-related stigma. Failing this, a minimum the Commission should conduct national research into self-stigma of priority populations such as the LGBTIQ+ communities.

(b) Beneficence of community-controlled service providers in tackling specific stigma and discrimination suffered by priority populations they serve

Furthermore, there is an absence of an express recognition of the salience of care provided by LGBTIQ+ community-controlled organisations. 'Community-controlled' organisations are operated by and for their communities and have governance structures to ensure the organisation is accountable to members of those communities. Being community-controlled enables organisations such as those run by members of the LGBTIQ+ communities and those living with HIV (such as Thorne Harbour Health) the ability to deliver trusted, safe, holistic, and culturally appropriate services to the communities they serve, while also advocating for solutions that advance the quality of life of their members.

No matter how well trained and affirming mainstream services are, there will always be a portion of LGBTIQ+ community members who prefer to use trusted community-controlled services. The role of community-lead organisations was recognised in the Royal Commission, noting that 'the non-government, peer led nature of many community led organisations can be empowering for community members, particular for people who, for a range of reasons, have been unable to access care or who have not experiences safe, responsive and inclusive care in government services".

Community-controlled organisations host expertise in dealing with the intersection of both stigma associated with mental health and stigma associated with minority disadvantage. On the other hand, mainstream services are ill-equipped to address and tackle issues associated with

stigma and discrimination suffered by priority populations due to the intersecting nature of minority stress and disadvantage with poor mental health.

(d) Clear funding strategy for leveraging or enlivening capacity of organisational expertise to ensure roll-out of strategy and associated resource development

(e) Clear, identifiable and progressive benchmarks that apply uniformly across all state and territories

(f) Express inclusion of quotas

Noting the imposition of particular advisory committees or boards within the strategy (i.e. 2.2g; 4b)., there must be an imposition of quotas of particular minority groups as members. This will serve to provide a variety of diverse perspectives on how to best effectuate change from an intersectional and nuanced lens. For example, quotas should prescribe positions held by minority population groups including, but not limited to, LGBTIQ+ persons, Aboriginal and Torres Strait Islander persons, those from CALD backgrounds, those living with a disability, those living rurally, and any and all other persons belonging to priority populations.

Failing this, there should be a strong commitment from the government to ensure that diversity is representative of any committee's or board's membership.

(g) Measurement of stigma

Whilst this strategy is aspirational in nature, there is no accurate measurement of stigma or associated benchmarks acknowledging progress made with respect to any and all reductions in stigma related to mental illness. Particular initiatives can be completed by the government, but it should be noted there is no imposition of community surveys, ongoing evaluation of community perspectives after such initiatives have been completed that could operate to measure, albeit crudely, whether any reduction in stigma has actually occurred.

Recommendations

1. For any prospective strategy to consider, or ideally expressly include, LGBTIQ+ communities within appropriate actions where other priority populations are mentioned.

2. For any prospective strategy to expressly mention the beneficence of community-controlled organisations in tackling stigma and discrimination by priority populations, and where appropriate, refer to them in relevant actions.

3. For any prospective strategy to expressly include quotas within any and all advisory committees or boards so as ensure appropriate diversity is consulted and reflected.

4. To undertake a significant analysis, or fund research into available and appropriate measurements of stigma that can be attached to the strategy in forming appropriate identifiable and progressive benchmarks.

Conclusion

Thorne Harbour Health extends its warm thanks for the National Mental Health Commission in developing this draft strategy that will undoubtedly serve a useful tool in the arsenal of governmental efforts of elevating mental health and wellbeing amongst the Australian population.

As Thorne Harbour Health as highlighted above, stigma remains a complex, multi-faceted phenomena that permeates all aspects of society that requires an ongoing, pervasive, targeted and systematic interventions.

Despite the draft strategy demonstrating impressive research, priority populations must form a larger part of any prospective strategy as the compounding layers of stigma associated with being a minority population acts as a significant hindrance in exposure, discussion, awareness, recognition, understanding, and delivering effective care.

Similarly, community-controlled organisations are positioned as specialist organisations that model best practice in tackling not only mental health stigma, but also the interrelated stigma associated with minority status and intersectionality. Thus, community-controlled organisations present as an indispensable scholastic resource for any prospective strategy to develop any educational or health promotion materials to be publicly disseminated.