Low Prevalence Disorder Component of the National Study of Mental Health and Wellbeing Bulletin 6

Stigma and discrimination

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Stigma and discrimination

A Bulletin of the Low Prevalence Disorders Study

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Low prevalence component of the survey:

People living with psychotic illness: an Australian study 1997-1998

People living with psychotic illness: an overview (Bulletin 1)

Costs of psychosis in urban Australia (Bulletin 2)

Employment and psychosis (Bulletin 3)

The use of psychopharmacological and other treatments by persons with psychosis (Bulletin 4)

Disability, homelessness and social relationships among people living with psychosis in Australia (Bulletin 5)

Stigma and discrimination (Bulletin 6)

Child and adolescent component of the survey:

The mental health of young people in Australia

Adolescent depression (Leaflet 1)

Conduct disorders (Leaflet 2)

Adolescent suicide (Leaflet 3)

Attention deficit / hyperactivity disorder (Leaflet 4)

Foreword

The unkind word, the glance aside, the social exclusions, higher insurance premiums or some denial of a human right. Stigma against those of us with a mental illness takes so many forms. It is insidious and it is all too common. Daily it accumulates and may erode our self esteem. Stigma robs us of opportunities others take for granted in society.

The cost of stigma is high. As a society we all pay for it. For in stigmatising people who experience mental illness, society not only adds to the difficulties those of us with a mental illness may face – society also casts us as 'other', marginalising us and thereby preventing us from contributing to and enjoying the fullness of community.

Stigma against people who have experienced a mental illness is deeply entrenched in our culture. It finds expression everywhere from the Parliament to the front bar. From courtrooms and pulpits to playgrounds it is possible to hear people who experience mental illness cast in an unfair light. As damaging as it is, such entrenched stigma calls for more than an emotional response from consumers, carers and those that support our rights in society. We need to develop informed strategies to counter stigma in all its guises. To be better able to change attitudes and educate the public about the reality of mental illness and the lives of those affected by it, we need to understand stigma's origins and the fears and prejudices that motivate it.

Dispelling stigma against those of us who experience mental illness will improve the quality of our lives and is fundamental to the mental health reform we are calling for.

This report presents the nature of the problems associated with stigma and through its recommendations suggests positive strategies to genuinely impact on stigma in our society. I welcome it as a resource for real change.

Simon Champ

Simon Champ is a pioneer of mental health consumer advocacy in Australia, and is a member of the Board of SANE Australia.

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Acknowledgements

1. Introduction

The top-ranking factor that Australians with mental illness say would improve their lives is *reducing stigma*. This was the main finding of a national 'phone-in' conducted by SANE Australia during Mental Health Week in October 2000. According to a report of this survey, misunderstanding of mental illness and discrimination affects all aspects of peoples' lives – even their treatment by mental health services.

The term 'stigma' means a mark or sign of disgrace or discredit, and 'to stigmatise' means to regard a person as unworthy or disgraceful. The consequences of being regarded in such a way include shame, humiliation, ostracism and despair. The burden of mental illness is thus made even heavier, not only by the direct effects of stigmatisation but by the profound injustice in being thus regarded. The matter of stigma, then, is not merely one of community attitudes and attempts to change them. It is a human rights issue as well.

Likewise, discrimination, the unfavourable treatment of a person based on prejudice, is also a matter of human rights and cannot be tolerated in a society that is committed to justice and a 'fair go' for everyone.

2. The effects of stigma

The symptoms of psychosis are the main focus of treatments aimed at improving quality of life. In contrast, the personal experience of stigma, which is also of great detriment to quality of life, is rarely given priority in treatment by either the community or mental health professionals (Gingerich, 1998). Yet the Report of the National Inquiry into the Human Rights of People with Mental Illness noted that 'People with mental illness experience stigma and discrimination in almost every aspect of their lives' (Human Rights and Equal Opportunity Commission, 1993, p. 925).

Stigma promotes and reinforces social isolation (Farina et al., 1992; Link et al., 1997), limits equitable opportunities for employment and recreation (Farina & Felner, 1973; Leete, 1992; Markowitz, 1998), discourages treatment-seeking by those who need it (Dubin & Fink, 1992; Sartorius 1998), creates, reinforces and sustains pseudo-psychiatric mythology, and is frequently internalised by people with a mental illness resulting in much suffering (Markowitz, 1998). While patients, carers and mental health professionals are frequently able to describe personal experiences of stigma, it is often difficult to prove that these experiences are the direct result of negative attitudes or that discriminatory action has occurred (Sartorius, 1998).

Sartorius (1998) states that:

> ...stigma and discrimination are the most significant obstacles to the development of mental health care and to ensuring a life of quality to people suffering from mental illness... there is enough money around to help those with mental illness but it is not available because of the attitude of most decision makers and a large part of the general public towards mental illness and all that surrounds it. (p1058)

There is evidence that in countries where less stigma is attached to mental illness, the prognosis of illnesses such as the psychoses is better, although linguistic and cultural issues may also have influenced this finding (Littlewood, 1998).

The Low Prevalence Disorders Study (LPDS) did not incorporate measures of stigma and discrimination experienced by people with psychotic disorders. However, some data gathered in the study could be interpreted as indirect evidence of stigma and discrimination. The LPDS was a national study conducted in predominantly urban catchment areas of the Australian Capital Territory, Queensland, Victoria and Western Australia between 1997 and 1998 (Jablensky et al., 1999). The LPDS participants (N=980) were identified using a census-based approach and interviews were undertaken using a specially designed instrument (Diagnostic Interview for Psychosis) covering demographic details, living circumstances, symptoms, level of disablement and service utilisation. Some information from this study will be reported in subsequent sections of this bulletin.

3. Stigma and the media

The mass media is often blamed for the creation and dissemination of stigmatising attitudes towards psychotic illness, and it is true that the images of people with schizophrenia as dangerous and unpredictable are consumed voraciously by much of the general public (Henderson, 1996). In the British popular press, it is not uncommon to read the labels 'maniacs', 'schizos', 'psychos', and 'nutters' in the tabloid newspapers (Ferriman, 2000). With such flagrant displays of prejudiced attitudes, it is easy to define the problem as belonging to 'the media'. Even the traditionally more responsible media in the UK, such as the broadsheets, overwhelmingly tend to portray people with mental illness as being potentially harmful to others, both in fictional and non-fictional representations (Philo et al., 1996).

The Australian media may be somewhat more discreet in their depiction of psychosis, yet the assertion that Australian media coverage of mental illness 'has gradually caught up with medical treatment and changed community attitudes' (Grainger, 1998) is premature. It has been suggested that as the Australian media have become better informed they have tended to avoid presenting negative stories of mental illness, but they are also seen to be less inclined to present positive images of mental illness, presumably because the material is less 'saleable' (Penrose-Wall, 1995). On the other hand, promoting awareness of mental illness through the media in a positive manner requires creativity, innovation and 'media-awareness'. It is said that if this done in a 'marketable' way, most mainstream media sources will present positive stories (Bogle, 1995).

The Commonwealth Government, through the Mental Health and Special Programs Branch, is currently funding a project to monitor overall coverage of mental illness and suicide in the media, the Media Monitoring Project. This is based at the Universities of Canberra and Melbourne. A Media Reference group has also been established by the Branch, with wide representation from various stakeholders, to provide expert advice and direction on the Mental Health Promoting Media Strategy and the Life Promoting Media Strategy.

The National University Curriculum Dissemination Project is an innovative program being undertaken by the Hunter Institute of Mental Health in collaboration with the University of Newcastle, and funded by the Commonwealth Department of Health and Aged Care. This program aims to provide curriculum resources for relevant disciplines such as journalism so that graduates will be more aware of and effective in their responses to the issues of mental health promotion and suicide prevention. Participation in this program is expected to have favourable outcomes in terms of media representation of mental illness. Further information is available at www.himh.org.au/response-ability, the project's website.

Recommendation 1.

That the media be actively challenged when portraying a stigmatising or misinformed depiction of mental illness. Use of the SANE stigma watch website at <u>www.sane.org</u> is an appropriate vehicle, among others, for such challenges.

Recommendation 2.

That members of the media who provide accurate and non-stigmatising coverage of issues related to mental illness be actively and, where appropriate, publicly acknowledged by SANE and other consumer, carer and professional organisations, thus encouraging further positive representations.

Recommendation 3.

That members of the media be informed about the availability of education and training programs in relation to mental health matters, such as the National University Curriculum Dissemination Project <u>www.responseability.org.</u> Further, encouragement to participate in such programs should be provided for members of the media by means of appropriate incentives.

4. Stigma and the community

4.1 Stigma and public attitudes

It is not clear whether the media influences popular conceptions of people with psychosis, or whether they merely reflect such attitudes. However, both within the media and amongst the general public, the mentally ill tend to be perceived as dangerous (Philo et al., 1996). Other studies have also shown that people with schizophrenia are viewed as likely to become violent towards others (Link et al., 1999; Pescosolido et al., 1999).

In fact, people with psychotic illnesses are often victims of violence. The LPDS (Jablensky et al., 1999) revealed that 15.3% of people with a psychotic disorder (17.2% of males, 12.4% of females) did not feel safe in their present neighbourhood. In addition, 17.6% reported having been physically assaulted, beaten, molested, or otherwise a victim of violence in the previous twelve months, and 13.2% indicated that they would have liked police or legal help but were unable to get it.

People with schizophrenia are also regarded as unable to manage money (Pescosolido et al., 1999), a trait particularly offensive to certain beneficiaries of advanced free market economies in which institutional bankruptcy is often better tolerated than failure to manage one's meagre finances. Most people with psychotic disorders have very little money to spend. The rate of unemployment among the LPDS participants was 72%, and of those who were employed only one third had worked full time in the past year and about two thirds were in positions requiring elementary or intermediate skill levels.

Lastly, people generally desire only limited social interaction with the mentally ill (Link et al., 1999). Indeed, social isolation is widespread among people with psychotic disorders. In the LPDS 63.5% of participants were single, 31.3% lived alone and there were very low rates of participation in shared household activities. Almost forty percent reported having no 'best friend' with whom they could share thoughts and feelings, and 44.9% felt in need of 'good friends'. Satisfying sexual relationships were reported in only a minority of the LPDS participants.

Although evidence from the literature supports a public image of persons with mental illness as one of potential violence, financial incompetence and social undesirability, the situation is rather more complicated than this. Research has shown that the community tends to report 'ideal' attitudes rather than their own private beliefs when questioned about mental illness (Link & Cullen, 1983). This suggests that opinions expressed by the public in surveys may not accurately reflect the manner in which people are actually likely to behave towards the mentally ill, if they act in accordance with their real beliefs. Thus, prejudiced attitudes towards the mentally ill may run deeper than people are prepared to admit. It is also unclear whether social action against stigma has a positive impact upon those who hold prejudiced beliefs or improves their behaviour towards the mentally ill.

> **Luke**
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> Luke, 18, experienced a cannabis-induced psychotic episode. During the psychosis, he believed that his friends were conspiring to hurt him and steal his belongings. His parents sought treatment for him, and with medication his symptoms resolved. However, his unusual behaviour during the psychosis was noticed by his friends. Although some were supportive, several young men have taunted Luke, calling him a 'schizo' and trying to provoke him into physical fights.

4.2 Combating stigma in the community

Increased knowledge about diseases that have historically carried the burden of stigma (eg, leprosy, epilepsy and syphilis) gradually reduced the stigma associated with them. As with these diseases, there is similar scope for public attitudinal change towards people with a mental illness (Porter, 1998). Some important Australasian initiatives have been designed to counteract the stigma of mental illness. For example, the group Stereotypes and Tags Interest Group in the Mental health Area (STIGMA) has been established to study and counteract stigma associated with mental illness (Walter, 1995; Walter & Rosen, 1997). SANE Australia, a national charity, has established 'Stigma Watch' as a means of reporting inappropriate and/or inaccurate media references to mental illness. In addition, SANE has provided consultation to the makers of 'Home and Away' to insert a story about a young man with a psychotic illness (Rosen et al., 2000). Similar efforts to combat stigma are also apparent on a global level with the 'Open the Doors' World Psychiatric Association (WPA) Global Program to Reduce Stigma and Discrimination Associated with Schizophrenia (Sartorius, 1997, 1998; Rosen et al., 2000).

Overwhelmingly, studies of public attitudes towards the mentally ill find that previous contact with a mentally ill person is associated with more positive attitudes and less stigma (Kommana et al., 1997; Penn et al., 1994; Penn et al., 1999). It is therefore possible that initiatives encouraging greater integration of the mentally ill within the wider community, such as through employment opportunities, will promote interaction and perhaps reduce stigma through greater contact.

People of course rub shoulders every day with mentally ill individuals, but without knowing it. However, for many in the general population their only known exposure is to those whom they *perceive* as mentally ill – perhaps those who are homeless and untreated, seen talking to themselves or going through rubbish bins. This adds to stigma, as the high visibility of such people not receiving treatment and support means this is one stock image the public has of the mentally ill, an image which ties in with irrational views about people who are 'different' or 'unclean'. In the long-term, reducing this significant contribution towards stigma could be achieved through improved services, including specialist teams working with the homeless.

While anti-stigma campaigns constitute a useful approach, one of the most basic but important means of reducing stigma is the provision of good treatment and support. Just as treatments for mental illness must be grounded in a sound base of evidence for their efficacy, so community anti-stigma campaigns must include appropriate evaluations of outcome. Only in this way can we learn what will be effective and not repeat misguided or ineffective activities.

Recommendation 4.

That public campaigns against the stigma of mental illness continue to be supported financially by government, industry, professional organisations and non-government organisations, and include systematic evaluations of their effectiveness as an integral component of each campaign.

5. Self-stigmatisation and family stigma

It is customary to consider stigma as primarily a characteristic of others towards persons with mental illness. However, the process of self-stigmatisation is an important but less obvious manifestation of stigma that has profound negative effects on the wellbeing of the individual with psychosis (Gallo, 1994). A distinction has been drawn between 'felt' stigma and 'enacted' stigma (Scambler, 1998). 'Felt' stigma involves the individual fearing discrimination as a result of the illness, whereas 'enacted' stigma is the actual expression of discrimination by others towards the individual. It has been suggested that 'felt' stigma gives rise to a process of concealment in order to influence the impression one has on others. This may be more disruptive to the lives of the mentally ill than 'enacted' stigma.

This phenomenon is reflected in a study investigating the perceptions of and reactions to stigma in family members of first-admission psychiatric patients (Phelan et al., 1998). Although most family members reported that other people had not avoided them because of their ill relative's hospitalisation, half reported that they had concealed the hospitalisation in some way. While concealing the fact of the hospitalisation may reduce the potential for the experience of 'enacted' stigma, this study illustrates how 'felt' stigma affects the lives of the family members.

Reduced insight on the part of the patient may be related to feelings of self-stigmatisation (Johnson & Orrell, 1995). That is, patients who hold a negative view of mental illness are more likely to have limited insight into their condition, as the alternative is to accept a stigmatising label.

Recommendation 5.

> **That the psycho-education provided to individuals who have experienced a psychotic episode, along with their close family members, include a significant component devoted to issues relating to stigma and how to cope with it. In particular, those people experiencing a first episode of psychosis should be targeted at this critical time. In order to give effect to this recommendation it is essential to incorporate this element of psycho-education into standard therapeutic guidelines developed for the treatment of psychosis.**

6. Stigma and mental health professionals

It is unfortunate that stigmatising attitudes towards mental illness are present within the mental health professions themselves (Porter, 1998). It is both right and necessary that this should change as people with mental illness are not able to combat stigma in isolation, and the mental health professions need to get their own house in order before they can provide credible leadership. Stigmatising attitudes of mental health professionals may be related to their often somewhat pessimistic views on the outcomes of treatment for mental illness (Jorm et al., 1999). People with mental illness use three common strategies to avoid the ill effects of stigma (secrecy, selective avoidance or withdrawal, and educating others), but these strategies are associated with greater demoralisation and unemployment (Link et al. 1991). Stigma and discrimination are more strongly related to socio-cultural attitudes and concepts than patients' individual coping strategies (Link et al., 1991). The efforts of many groups, including the mental health professions, carers and families, as well as consumers themselves, will be required to combat ingrained discriminatory cultural attitudes.

Stigma and discrimination related to mental illness can be targeted by mental health professionals using a set of interventions suggested by Sartorius (1998). These are embodied in this recommendation.

Recommendation 6.

That the following interventions proposed by Sartorius (1998) should be considered for implementation by all professional organisations representing the clinical disciplines that work in mental health, namely:

- **Examine our own attitudes and capacity to deal with mental illness**

- **Become active and vocal advocates of the rights of the mentally ill**

- **Change the focus of attention in clinical work, research and teaching from clinical symptoms to exploring ways to increase the quality of life for those with severe mental illness**

- **Monitor for any signs of discrimination against the mentally ill**

- **Learn ways to effectively deal with stigma, and incorporate this as a standard aspect of discussions about psychiatry and society.**

In addition to these strategies, it is important that the mental health professions be attuned to the socio-cultural background of the patient as this is a significant determinant of the patient's own attitudes towards mental illness and must be taken into account when addressing issues of stigmatisation.

7. Discrimination against the disabled is illegal

The LPDS did not set out to measure discrimination among people with psychotic disorders. Nevertheless some data from this study can be interpreted as providing indirect evidence of discrimination.

In terms of housing and accommodation, the LPDS found that 3.5% of participants were homeless for at least some part of the year, 10.1% had lived in a crisis shelter or rooming house, and 15.3% had lived in a hostel. It would be naïve to assume that this was purely the result of societal stigma. Economic factors and the course of the illness itself are also contributing factors. However, it is conceivable that some landlords may feel that people with a mental illness make undesirable tenants and choose to let their housing to others.

> **Brett**
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> Brett, 35, was living in a shared house when he suffered a relapse of his psychosis and was hospitalised. When he returned from hospital, the people he had shared the house with said that he couldn't stay with them any more and that his room had been taken by someone else. They had packed his belongings and left them on the front porch where they had been pilfered by passers-by. Having nowhere to stay and unsure of what to do, he called the social worker at the hospital, who was able to arrange short-term emergency accommodation. Since then, Brett has lived in a range of boarding houses and shelters.

Education is often disrupted owing to the fact that many psychoses typically begin during the teenage years. The LPDS found that 50% of the sample reported an age of onset prior to 22 years, and 75% reported an age of onset prior to 28 years. Thus for a clear majority their psychotic illness began during a period of life that normally involves the pursuit of education, establishing a career, and developing one's role as a productive participant in the community. Of the LPDS sample, 47.8% left school without a qualification. A further 17.9% finished high school, but did not gain further qualifications. Only 34.3% of the sample obtained higher qualifications than high school. In addition, only 15% of the entire sample reported that in the previous year they had been involved in any kind of further education. This is clearly an educationally disadvantaged group. The extent to which stigma contributes to this disadvantage, or vice versa, is not known.

> **Sara**
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> Sara, 28, wanted to enroll in a local business college to obtain formal qualifications she could use to apply for work. When she enquired into the cost of the course she was disappointed to find that her Disability Support Pension was insufficient to cover the fees and leave a sufficient amount for her to live on.

A further indirect measure of discrimination may be found in the extent of use of certain agencies by people with psychoses and the degree to which those services met the users' needs. Participants in the LPDS were asked to rate whether they had used a range of agencies in the 12 months prior to the interview. Those who had used such an organisation or service were also asked whether their needs had been met. The results are provided in the Table below. For every agency except Ethnic Services, respondents with greater levels of disability were more likely to report unmet need than respondents who were not so impaired. There are several factors that may account for these differences. For example, it may be that services are less effective in providing support for people seriously impaired by mental illness. Whether the extent of unmet need reflected in this table can be attributed to direct discrimination against people with psychotic disorders could not be determined within the scope of the LPDS.

Table. Agencies contacted and adequacy of service provided.

Agency	Contacted agency (%) [a]	Agency used, needs not met Impaired? [b]	
		No	Yes
Department of Social Security	68.5	11.0	15.4
Church	36.7	12.4	16.1
Other community organisations	25.8	11.0	11.8
Commonwealth Employment Service (CES)	25.4	37.3	51.6
State housing	24.5	24.2	35.2
Mental health self-help organisations	17.3	21.7	33.3
State Legal Aid	14.9	36.5	38.6
Community counselling	12.8	32.8	39.7
Local council	11.9	27.5	58.3
State community services	8.8	51.3	53.2
Ethnic services	5.8	66.7	60.6
Family Court counsellors	4.7	83.3	86.4
Veterans Affairs	4.3	81.0	95.2

[a]   An individual may have contacted more than one agency in the year prior to interview.

[b]   Impairment level was based on the Social and Occupational Functioning Assessment Scale scores. Serious or major impairment was rated as impaired; no serious or major impairment was rated as not impaired.

The Commonwealth *Disability Discrimination Act 1992* was established with the stated aims of eliminating, as far as possible, discrimination against people on the ground of disability in areas such as work; accommodation; education; access to premises, clubs and sport; provision of goods, facilities, services and land; existing laws; and administration of Commonwealth laws and programs. The Act also aimed to ensure that as far as practicable, persons with disabilities have the same rights to equality before the law, and to promote recognition and acceptance within the wider community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.

Included within the Act's defining criteria of 'disability' are conditions involving 'total or partial loss of the person's bodily or mental functions' as well as a 'disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement or that results

in disturbed behaviour'. Clearly, the symptoms of psychotic illness fulfil the criteria of a disability under the *Disability Discrimination Act 1992*. In addition, the typically episodic course of psychotic illness is covered by the Act, which caters for disability that presently exists, previously existed but no longer exists, may exist in the future, or is imputed to a person.

Given that psychotic disorders fall under the protection of the *Disability Discrimination Act 1992*, it is important to consider the scope of the Act. The Act defines both direct disability discrimination (s 5) and indirect disability discrimination (s 6). In terms of employment, the Act makes discrimination on the basis of disability unlawful (for example, in relation to hiring, terms of employment, promotion and dismissal) where the individual could perform the inherent requirements of the position. Discrimination is unlawful regardless of whether reasonable accommodation of the disability is necessary, so long as such a reasonable accommodation would not impose unjustifiable hardship on the employer. The Act applies to discrimination against employees (s 15), commission agents (s 16), contract workers (s 17), and partnerships (s 18) exercised by state and federal governments, as well as private corporations (s 12), qualifying bodies (s 20), and employment agencies (s21). The Act also holds employers liable for any discrimination exercised by their employees or agents (s 123).

While employment is perhaps the most obvious area in which discrimination occurs against those with mental illness, the *Disability Discrimination Act 1992* is also concerned with discrimination exercised outside the employment arena. The Act, if properly enforced, would significantly improve the quality of life of those with psychotic illness in a wide range of areas. For example, the Act proscribes discrimination on the ground of disability by an educational authority in refusing or failing to accept an application for enrolment, or in the terms or conditions of enrolment. In addition, it is unlawful for the educational authority to deny or limit a student's access to benefits provided by the authority, either by expelling the student or subjecting the student to any other detriment based on the disability (s 22). Similarly, it is unlawful for a person to discriminate against another with a disability by refusing an application for accommodation, by deferring the application or placing it on a lower order of precedence in any list of applicants, or in the terms and conditions of such accommodation (s 25). Sections of the Act also proscribe discrimination based on disability in the area of provision of goods, services or facilities (s 24); disposing of land (s 26); membership and terms and conditions of clubs (s 27); and exclusion from participation in sporting activity (s 28). In addition, most of the sections of the Act also apply to discrimination against persons who have an associate with a disability. Therefore, the Act makes unlawful any discrimination against spouses, families, carers, and those in business, sporting, or recreational relationships with a person with a disability.

Given the protection afforded by the *Disability Discrimination Act 1992*, it is no longer legally or morally acceptable for people with severe mental illness to experience discrimination in their daily lives. Calls for 'education' and 'understanding', by themselves, have thus far been insufficient. It is now appropriate to supplement campaigns for education and understanding with more stringent monitoring and enforcement of the Disability Discrimination Act 1992, and those who commit breaches of the Act in relation to people suffering from psychotic disorders must be held accountable for their actions. Injustices faced by those with mental illness in attempting to access goods and services, employment, education and accommodation must cease. The *Disability Discrimination Act 1992* ought to be used where necessary to enable people with psychotic disorders to participate fully in their communities.

It should also be noted that the Human Rights and Equal Opportunity Commission can provide advice and can undertake legal action on behalf of mentally ill persons. In addition, the Commonwealth funded Disability Discrimination Legal Advisory Service, which has an office in each state, can take a role on behalf of the mentally ill in relation to the *Disability Discrimination Act 1992*.

Recommendation 7.

That enforcement of the *Disability Discrimination Act 1992* be actively monitored, and those committing breaches of the Act be prosecuted. Advocacy and support should be provided to enable individuals who are victims of breaches of the Act to seek redress on legal grounds, by initiating prosecutions under the Act if necessary. Financial assistance through Legal Aid Services and other organisations should be provided for this.

8. Summary

The evidence available in the literature, indirectly supported by some of the findings of the LPDS, indicate that for the many people with a psychotic illness, stigma and discrimination are common. Stigma can have a negative influence on several important dimensions of community-living including housing, education, personal safety, employment and social activity. The fact that these experiences do not appear to be crippling is testament to the resilience, courage and adaptability of people with psychoses, qualities that could be put to more beneficial use for everyone if channelled into greater and more productive participation in the community. In addition to combating stigma through the conventional means of community education and persuasion, and by promoting greater community participation by the mentally ill, it is also necessary for individuals, alone or in conjunction with others, to make timely use of the Disability Discrimination Act to ensure their full participation in the life of the Australian community.

Summary of recommendations

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- Become active and vocal advocates of the rights of the mentally ill;

- Change the focus of attention in clinical work, research and teaching from clinical symptoms to exploring ways to increase the quality of life for those with severe mental illness;

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- Learn ways to effectively deal with stigma, and incorporate this as a standard aspect of discussions about psychiatry and society.

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