Discrimination and positive treatment towards people with mental health problems in workplace and education settings: Findings from an Australian national survey

Abstract

The aim of the study was to carry out a national population-based survey in order to estimate the prevalence and explore the nature of experiences of work and education-related avoidance, discrimination and positive treatment in people with mental health problems. In 2014, telephone interviews were carried out with 5220 Australians aged 18+, 1381 of whom reported a mental health problem or scored highly on a screening questionnaire. Questions covered work- and education-related avoidance, discrimination and positive treatment. The results showed that those in work or in education reported higher levels of positive treatment than discrimination or avoidance, while people looking for work experienced higher levels of discrimination than positive treatment. The most common types of discrimination included dismissive treatment or lack of understanding of the illness, being forced to change responsibilities or denied opportunities at work, and not being given leniency or special consideration in education. Among those reporting discrimination when looking for work, 51.4% said that they had not been hired because of their mental health problems, while 10.8% focused on anticipated discrimination and mentioned not disclosing their mental health problems during the recruitment process for fears that doing so would have resulted in a negative reaction from prospective employers. The results can provide input into the design of anti-discrimination interventions, particularly for people with mental health problems who are looking for work. This may include supporting people with mental illness to overcome anticipated discrimination and education of employers to support stigma reduction.

Key words: mental disorders; discrimination; stigma; positive treatment

Background

The ability to work plays a critical role in mental and physical wellbeing (LaMontagne, Keegel, Louie, & Ostry, 2010; Wilkinson & Marmot, 2003). Work is a primary determinant of socioeconomic position and plays a key role in social connectedness, the development of identity and self-esteem. Mental health problems increase the risk of failing to achieve good educational and vocational outcomes and can result in social and economic marginalisation (Kessler et al., 2008; Levinson et al., 2010). Data from the 2011-2012 National Health Survey showed that the employment rate for Australians aged 16-64 years with a self-reported mental illness was 62%, only three quarters of the rate for people without a mental illness (80%) (Australian Bureau of Statistics, 2012). Participation rates in those with low prevalence disorders are even lower. The 2010 Australian Survey of High Impact Psychosis (SHIP) showed that only 22.4% of people with psychotic disorders were employed in the month prior to the survey. Of those in competitive employment, the majority worked part-time (63.9%). Only 31.9% of respondents had completed high school.

Barriers to employment in people with mental health problems are multifaceted and complex and include those related to illness and treatment, attitudes and aspirations towards work and education, the service system, financial disincentives to work and stigmatising attitudes and discrimination (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; McDowell & Fossey, 2015; Rutman, 1994; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Studies of employers' attitudes towards employees with mental health problems have shown relatively low levels of awareness and limited capacity to deal with these issues in the workplace (Brohan, Henderson, Little, & Thornicroft, 2010; Little, Henderson, Brohan, & Thornicroft, 2011). A limited number of studies have attempted to assess work-related discrimination in people with mental health problems, but these have typically assessed experiences in clinical populations or people with one specific disorder (most commonly schizophrenia) (Lasalvia et al., 2013; Thornicroft et al., 2009). There is relatively little published data on the prevalence estimates of work-related discrimination in the general

population. A US study, in which questions about job-related discrimination were incorporated into the 1994-1995 National Health Interview Survey–Disability Supplement, reported past 5 -year prevalence estimates of discrimination of 20% among workers with mental illness (Baldwin & Marcus, 2006). A recent Canadian study, in which stigma questions were incorporated into the Canadian Community Health Survey, reported workplace and school-related discrimination rates of 28% in people who had been treated for a mental illness in the year prior to the survey (Stuart, Patten, Koller, Modgill, & Liinamaa, 2014). However, there was limited further exploration of the nature of these experiences.

In the education setting, mental illness has been shown to affect both exam performance and higher education drop-out rates (Andrews & Wilding, 2004; Hysenbegasi, Hass, & Rowland, 2005; Kessler, Foster, Saunders, & Stang, 1995). Schools and tertiary education institutions typically offer a number of services to support students with a mental illness, including counselling services and disability liaison units. While assessment of stigmatising attitudes in young adults is relatively common (Amarasuriya, Jorm, Reavley, & Mackinnon, 2015; Reavley & Jorm, 2011), there have not been any studies systematically assessing experiences of discrimination in tertiary education students.

Moreover, no population-based studies have systematically assessed experiences of positive treatment reported by people with mental health problems in either the workplace or education settings. This is despite the development in many countries of interventions aiming to assist employers to better address mental health issues in the workplace (Little et al., 2011; McDowell & Fossey, 2015; Wagner et al., 2016) and the widespread implementation of policies to assist students with mental health problems (Reavley, Ross, Killackey, & Jorm, 2013).

Therefore, the aims of the current study were to carry out a national population-based survey in order to estimate the prevalence and explore the nature of experiences of work and education-related avoidance, discrimination and positive treatment in people with mental health problems. The survey covered experiences reported by people with mental health problems and reports of

those who had observed these experiences in a person with mental health problems known to them, in order to assist in clarifying the issue of whether personal reports of discrimination are due to distorted perceptions.

Methods

The survey involved computer-assisted telephone interviews (CATI) with a national sample of 5220 members of the Australian general community aged 18 and over. Further methodological detail is available in (Reavley & Jorm, 2015). The survey was carried out by the survey company The Social Research Centre. A 'dual frame' approach was used, with the sample contacted by random-digit dialling of both landlines and mobile phones. This approach was taken in order to minimise the potential bias of collecting data solely from households with a landline telephone connection, as the latter approach may under-sample young people, particularly young men (Holborn, Reavley, & Jorm, 2012; Hu, Balluz, Battaglia, & Frankel, 2011). Interviews were conducted between October and December 2014. The average interview length was 19.4 minutes. Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee.

Survey interview

After initial questions covering sociodemographic information (age, gender, marital status, postcode, country of birth, language spoken at home, level of education and Aboriginal and Torres Strait Islander status), respondents were taken through the 12-month version of the Kessler 6 (K6) mental health symptom screening questionnaire (Kessler et al., 2010). This questionnaire asks participants to think about one month in the last 12 months when they were most depressed, anxious, or emotionally stressed. Respondents were also asked whether, over the last 12 months, they had experienced any sort of mental health problem (defined in the preamble to the question in the following way: "a period of weeks or more when you are feeling depressed, anxious, or emotionally stressed, and these problems are interfering with your life. Mental health problems could include,

for example, depression, anxiety disorders, eating disorders, schizophrenia, bipolar disorder, or personality disorders"). Those respondents who answered yes to this question were then asked what they thought the problem was. Respondents who specified any of the following mental health problems were considered in scope: depression/major depression, attempted suicide or self-harm, anxiety/anxiety disorder, post-traumatic stress disorder/PTSD, agoraphobia, panic disorder, obsessive-compulsive disorder/OCD, social phobia, generalised anxiety disorder/GAD, eating disorder/anorexia/bulimia, schizophrenia/paranoid schizophrenia, schizoaffective disorder, psychosis/psychotic, bipolar/bipolar disorder/manic-depressive disorder, mental illness, personality disorder/borderline personality disorder, attention deficit-hyperactivity disorder/ADHD, Autism/Asperger's and nervous breakdown. At this point, survey respondents were divided into two groups: (1) those who scored in the 'high' range on the K6 (equal to or above 19) or who reported having had an in-scope mental health problem; and (2) those who did not meet these criteria.

Those in the first group were asked if they had done paid or voluntary work outside the home during the past 12 months. Those who had were then asked the following questions: "Have any people in the workplace avoided you because of the emotional or mental health problems you have told me about?"; "Have you been discriminated against in other ways to do with your employment or because of these problems (this could include changing jobs or applying for promotion)?" "Can you please describe what happened?"; "Have you been treated more positively in any way relating to your employment because of these problems?"; and "Can you please describe what happened?". Subsequently respondents were asked if they had been looking for work or had attended school, college or university in the past 12 months. Those who had were then asked questions similar to those above, with the exception of the question about avoidance for those looking for work.

In a subsequent section of the questionnaire, all respondents were asked whether they knew any adult with a mental health problem (see definition above). Those who reported definitely knowing someone in this category were asked if there was more than one person. In such cases, they were

asked to think about the person they knew best. They were asked about the mental health problem the person had, how they knew the person had the problem, as well as the person's age, gender and relationship to the respondent. Those that knew someone with an in-scope mental health problem (see definition above) were asked the following questions (with a past 12-month timeframe specified in the introduction to this section of the questionnaire): "Did any people in the workplace avoid them because of their mental health problems?", "Did any people in the workplace discriminate against them in other ways because of their problems?", "Did any people in the workplace treat them more positively because of their problems?". If the respondent answered any of these questions in the affirmative, they were then asked: "How did you find out about this happening - Did you observe this happening yourself or did the person or someone else tell you about it?". The same questions were asked for people looking for work and people in the place of education, with the exception of the question about avoidance for those looking for work. The same questions were also asked for the following people or situations: spouse or intimate partner, other members of the family, health professionals, other people in the community or neighbourhood and other people and other situations. The data on these latter questions are reported elsewhere (ref removed for blind review).

Statistical analysis

The data were analysed using percent frequencies and 95% confidence intervals. A pre-weight was applied to adjust for the dual frame design and the respondent chance of selection. The achieved sample was close to the Australian national population in terms of geographic distribution, however, there was an under-representation of males and of younger adults, and an over-representation of university-educated individuals and people with an English-speaking background. These biases were adjusted for by 'raking' (also known as rim weighting or iterative proportional fitting) to account for known population proportions of gender, age, education level, region and telephone status (with age and gender based on Australian Bureau of Statistics (ABS) data of March 2014 (Australian Bureau of Statistics, 2014b), level of education and region based on ABS 2011 census data

(Australian Bureau of Statistics, 2014a) and telephone status based on 2011 Australian Communication and Media Authority data (Australian Communication and Media Authority, 2014)). All analyses were performed using Intercooled Stata 13 (StataCorp LP, Texas, USA).

Coding of open-ended responses

The analysis aimed to identify key characteristics of experiences of discrimination and positive treatment. For each setting, all verbatim responses to the open-ended questions were initially analysed by one of the authors (AJM) to develop a draft coding system with instructions, examples and counter-examples. These instructions and a sample of responses (or all of them when few in number) were then provided to one of the other authors (NJR) to independently code. Agreement was assessed and any discrepancies discussed, with changes made to the coding categories and instructions if necessary. More than one category could be used to describe a single incident or behaviour. Once the coding framework was finalised, the full sample was then coded by one of the authors (AJM), with discussion with a second author (NJR) for some responses when necessary. Responses that could not be interpreted, did not make sense, or required very strong assumptions about the respondent's meaning were not coded. Responses were also not coded if they detailed discrimination that was not related to mental health (e.g., age, race, criminal record).

Results

Overall, 5220 interviews were completed, with 2589 on landlines and 2631 on mobiles. The standard response rate for the survey was 37.5%. 1381 (28.8%) respondents were asked the questions about personal experiences of avoidance, discrimination and positive treatment. Of these, 732 respondents had K6 scores of 19 or above and 1159 respondents had a mental health problem considered to be in scope. Among respondents with K6 scores above the cut off, 418 had received treatment. Among these respondents with an in-scope mental health problem, 783 had received a diagnosis and 771 had received treatment. Table 1 shows the demographic characteristics of the sample. The most common mental health problem was depression (55.6%), followed by anxiety

disorders (including PTSD and OCD; 45.2%), bipolar disorder (4.6%), psychotic disorder (2.7%), eating disorder (2.3%), and personality disorder (1.2%) (multiple diagnoses were possible). Thus, Of these, 992 (72.1%) reported being in paid or voluntary work outside the home, 410 (33.2%) reported looking for work and 317 (24.4%) reported attending school, college or university during the previous 12 months.

Additionally, 2703 (51.0%) respondents knew someone with an in-scope mental health problem in the previous 12 months, with the most common problems being depression (named by 1568 (49.8%) respondents), anxiety disorder (named by 726 (23.8%) respondents) and bipolar disorder (named by 500 (15.5%) respondents). When asked to describe their relationship with the person, 1271 (46.3%) respondents described them as a family member, 907 (34.3%) as a friend, 202 (8.1%) as a spouse and 158 (5.7%) as a work colleague. When asked how they knew the person had a mental health problem, 1626 (61.6%) respondents reported that the person had told them, 1363 (50.1%) reported that they recognised it and 644 (23.8%) reported that someone else told them. Of these, 1665 (61.5%) knew someone who was in paid or voluntary work outside the home, 729 (28.4%) knew someone who was looking for work and 457 (18.1%) knew someone who attended school, college or university during the previous 12 months.

Table 2 shows the percentages of respondents with personal experiences of avoidance, discrimination and positive treatment by people in the workplace and place of education, as well as avoidance, discrimination and positive treatment experienced in these settings by a known adult with a mental health problem. For personal experiences in the workplace, respondents reported a greater frequency of positive treatment experiences than avoidance or discrimination. However, respondents looking for work reported more experiences of discrimination than positive treatment. For experiences in other adults, a similar pattern was seen.

In the education setting, nearly a third of respondents reported they had been treated more positively because of their mental health problem by someone at their place of education. Reports

of avoidance or discrimination were much lower. For experiences in other adults, a similar pattern was again observed.

Qualitative content analysis led to the description of broad categories of experiences for each of the following domains (totals may add to more than 100% as responses could fit in multiple categories). Examples from each category are provided for illustration, with the respondent's gender, age group, and diagnosis given after each quote:

Discrimination in the workplace

Dismissive treatment or lack of understanding of the illness: 32 (26.9%) respondents reported that people at work did not believe that the respondent's illness was real, or that it was serious and caused suffering, or did not understand how mental health problems can affect behaviour and work performance.

> HR manager doesn't view it as an illness, views it as an attitude problem…(Male, age range 55-59 years, depression, anxiety disorder and bipolar disorder)

> People at work making it a bit difficult. Hard for them to understand the condition I actually suffer from. They treat me a bit different (Male, age range 30-34, depression and anxiety disorder)

> They put me down and laugh at it, they don't believe in it (Male, age range 20-24, depression and anxiety disorder)

Forced to change responsibilities or denied opportunities: 29 (24.4%) respondents reported being forced to take on fewer responsibilities, demoted, or denied opportunities at work because of their mental health problems.

> I tried to apply for a different position in my workplace and have been told that I can't because of my emotional state (Female, age range 18-19, depression and anxiety disorder)

Reluctance to give responsibility back. Less opportunities offered, as a result of me telling them about it. / You would have to earn your stripes again, feels like being back at square one (Female, age range 30-34, no diagnosis)

Not being given work because of my problems, they perceived what they thought I would be able to deal with rather than asking me (Female, age range 30-34, PTSD)

Fired/made redundant: 18 (15.1%) respondents reported an unwilling termination, suspension or redundancy because of their mental health problem.

I had a bit of a breakdown at work. And instead of being supportive they stood me down for a week without pay (Male, age range 50-54, depression)

Being judged/treated differently or treated as incompetent: 15 (12.6%) respondents reported being judged negatively, criticised, treated differently or treated as incompetent because of behaviour related to their mental health problem.

My previous employer just continually criticised my work and was not at all understanding (Female, age range 30-34, depression)

People do treat you a little bit differently. I had a little breakdown earlier on this year and I took a few days off work, and it got around the office and I've been told that I get emotional and I'm a bit paranoid… (Female, age range 45-49, depression)

People have avoided listening to my opinion or taking notice of what I've said and kind of dismissed me (Male, age range 64-69, depression)

Lack of reasonable adjustments: 8 (6.7%) respondents reported that the employer did not make accommodations to the job role or workplace to support the person to keep working or return to work, e.g. not giving time off when requested, not allowing a change in department or office location, not being allowed to modify work tasks.

I was looking for time off but I wasn't able to get it because it wasn't physical, a physical

problem (Female, age range 20-24, borderline personality disorder)

Reduced contact/exclusion: 6 (5.0%) respondents reported being avoided, excluded from work or

social events or having people stop talking to them.

When I was at work, people wouldn't talk to me when I was down (Male, age range 18-19,

depression and anxiety disorder)

Other experiences included resigning (8; 6.7%), being protected from fully performing their roles (1;

0.8%), being physically abused (2; 1.7%), being gossiped about (1; 0.8%) and being put on a

performance management plan (2; 1.7%). Four (3.4%) respondents reported anticipated

discrimination.

Positive treatment in the workplace

Non-specific support or help: 126 (54.3%) respondents mentioned getting support or more support

than usual.

I think my bosses appreciated the sit I was in and it's difficulties and generally were v

positive and friendly and supportive (Female, age range 60-64, depression)

I think people are just a bit more, you know, a bit more aware of, just by being a bit more

aware of a situation there's a bit more sensitivity, maybe (Female, age range 45-49,

depression)

Allowed time off: 45 (19.4%) respondents were given time off or had more flexibility in taking time

off (e.g. at short notice).

My boss was well aware of what was happening so whenever I needed a day off or time to

myself it was always available (Male, age range 20-24, no diagnosis)

Given time to deal with what was going on, if I had any issues I was told that I could ask for more time, they were really good with it (Male, age range 20-24, no diagnosis)

Flexibility with duties or hours worked: 42 (18.1%) respondents were given alternative duties, reduced workload, flexible hours or work location, less pressure to perform or help with work tasks.

I've been offered flexible working arrangements, my duties have changed slightly to accommodate some of my symptoms and generally received more support and more attention (Female, age range 55-59, anxiety disorder)

My boss came and had a meeting with me to see if she could make things less stressful (Female, age range 30-34, anxiety disorder)

They were more patient with me, if I needed a few minutes off. My boss would ask me if I needed more time off, if there was a duty I need to do she would step in (Female, age range 18-19, no diagnosis)

Increased contact/checking on them: 25 (10.8%) respondents reported that colleagues maintained or increased contact or checked in with them to see how they were going.

My boss has been really good, will ring and check on me regularly, checking I'm ok… (Female, age range 50-54, depression)

They've asked me how I am more often (Male, age range 25-29, depression)

They treated me better and talked to me more. They went out of their way to make me feel better (Female, age range 18-19, no diagnosis)

Talk/listen: 21 (9.1%) respondents reported that they were able to talk with someone at work about their issues, or the person at work listened/was willing to listen to the respondent talk about their issues.

Lots of words of encouragement and support and allowing you to talk and share you concerns and problems it's always that sort of stuff that gets people through (Female, age range 50-54, anxiety disorder)

The boss had always said if you want to talk about it, he's got an open ear, he's very understanding (Male, age range 30-34, depression, attempted suicide or self harm)

Encourage professional help: 17 (7.3%) respondents were encouraged or facilitated to seek help or professional help for their problem.

Over the last couple of weeks they gave me some time off and referred me to a counselling agency which I'm feeling really good about (Male, age 25-29, depression and panic disorder)

Other experiences included receiving advice (8; 3.4%), support with return to work (5; 2.2%), financial support (3; 1.3%), encouragement to undertake social and other activities (3; 1.3%), having efforts made to cheer them up (3; 1.3%), improved relationships (2; 0.9%) and being a respected role model (2; 0.9%).

Discrimination when looking for work

Not getting hired: 19 (51.4%) respondents reported not getting a job due to their mental health problem (or suspecting that as the reason), or once they disclosed it to the potential employer, the recruitment process didn't progress.

Possibly, went to a few interviews and that could be why I didn't get the job, they knew I had bipolar (Male, age 20-24, depression and bipolar disorder)

Soon as you mention a period of non work you are forced to disclose the depression and once they heard that word that's it. Sometimes I think it's worse than telling them you've been in jail. Once you mention that their face changes and their body language changes and you know you won't get the job (Male, age range 50-54, depression)

Anticipated discrimination: 4 (10.8%) respondents reported not mentioning their mental health problem during the recruitment process or fears doing so would result in a negative reaction from the employer and result in not being hired.

> It was a requirement of my job to do a psychiatric evaluation so they basically I had to discuss my mental health so I just lied to them to say I did not have any mental health issues (Female, age range 25-29, depression)

Other experiences included being asked about mental health issues during recruitment (2; 5.4%), treated as incompetent (1; 2.7%), forced to reduce responsibilities (1; 2.7%), treated dismissively (1; 2.7%), shown a lack of understanding (1; 2.7%) and being judged (1; 2.7%).

Positive treatment when looking for work

Non-specific support: 7 (33.3%) respondents reported that people were positive, understanding or supportive towards them.

> The new employer (I told them these issues) and they understood and empathised because it had happened to them in the past (Male, age range 25-29, depression)

> They would encourage me to go out day after day and start looking for work, and they would really get behind you and back you, and you fall backwards, they'll save you (Female, age range 40-44, anxiety disorder)

Job-seeking support: 6 (28.6%) respondents reported receiving structured job- seeking support from a social security office or employment services provider.

> I get support through the job network people, they offer good solid support, they helped me get a working with children's check done (Male, age range 30-34, depression and schizoaffective disorder)

I have a disability support agent but it seems like it takes a long time to get an interview, and I've got jobs on my own faster, but to do a course or to do some sort of funding course works well, but I was with them for 12 months and didn't even get an interview, but I did get the course, you're able to do courses which was ok (Male, age range 45-49, schizoaffective disorder)

Other experiences included informal advice on job seeking (2; 9.5%), being employed despite mental health problems (3; 14.3%) and that the employer saw benefits from employing someone with a mental health problem (1; 4.8%).

Discrimination in education

Lack of understanding: 8 (34.8%) respondents reported a lack of understanding about how mental health problems can affect behaviour and performance, or how to deal with them.

Not being not taking into consideration mental illness as a sickness. You have to have the flu or a broken leg and mental illness is not seen as a valid reason to hand in an essay late (Female, age 25-29, depression)

I get stressed and will cry if I'm too stressed. My teachers mostly just stare at me funnily and send me out of the room, it's not caring like, they send me to the office as a quick fix. They don't listen to my problems and I don't learn and I stress more. Teachers definitely need a little help (Female, age range 18-19, no diagnosis)

No leniency or special consideration: 7 (30.4%) respondents did not receive requested leniency or reasonable adjustments to accommodate their mental health problem.

When I gave them the letters from my doctor to reduce hours they didn't like it and said I was at risk of failing so I changed courses, they knew I had schizophrenia (Female, age range 20-24, schizophrenia)

Teasing/mocking: 5 (21.7%) respondents reported experiencing teasing, mocking, or derogatory comments from people at their place of education.

> I stopped studying basically because I thought I was worthless. People asked me what was happening, some were derogatory (Male, age range 18-19, depression and anxiety disorder)

> Sometimes I try to explain to a tutor why my assignment is late and they would roll their eyes (Female, age range, 20-24, depression and attempted suicide or self harm)

Other experiences included people being unwilling to listen (2; 8.7%), being treated as incompetent (2; 8.7%) and being overprotected (1, 4.3%).

Positive treatment in education

Special consideration: 64 (70.3%) respondents specifically mentioned being given special consideration or extra time to complete assignments, extra help or other adjustments.

Non-specific support: 23 (25.3%) respondents mentioned being positively treated, without giving specific details.

> Very encouraging and if they could sense that you were going through a rough patch they showed a bit of compassion to boost (Female, age range 30-34, depression)

Professional help: 8 (8.8%) respondents were encouraged to seek professional help or received professional help at their educational institution.

> At the start of the course I went to see the counsellors at TAFE. It helped me to keep going with the course, it was free and really good. It was really helpful (Female, age range 55-59, depression, anxiety disorder and eating disorder)

Other experiences include people checking on them (2; 2.2%), talking about their issues (4; 4.4%), receiving advice (2; 2.2%) and drawing on their experience (2; 2.2%).

Discussion

This paper reports results of the first national population-based survey to assess experiences of avoidance, discrimination and positive treatment by people with mental health problems in the workplace or place of education. The results showed that those in work or in education reported higher levels of positive treatment than discrimination or avoidance, while people looking for work experienced higher levels of discrimination than positive treatment. When reports of personal experiences of avoidance, discrimination and support were compared with reports of these experiences in other adults with mental health problems, similar patterns were seen.

Among those reporting discrimination when looking for work, over 50% said that they had not been hired because of their mental health problems, while 10.8% focused on anticipated discrimination and mentioned not disclosing their mental health problems during the recruitment process or feared that doing so would have resulted in a negative reaction from prospective employers. This latter finding should be interpreted in light of the fact that participants were not asked specifically about anticipated discrimination, with responses only coded in this category if participants mentioned it. Thus, it is likely to be under-reported compared to other surveys (e.g. (Thornicroft et al., 2009)). The findings highlight the need to address stigma-related issues as part of programs that aim to assist people with mental health problems who are looking for work (Viering et al., 2013). This may include self-stigma or stigmatising attitudes and discrimination by others in the workplace (Corrigan, Larson, & Rusch, 2009).

The results of the study also provide support for the further implementation of workplace anti-stigma interventions, which may benefit those who are looking for work and those currently in employment. For those in work, the most common types of discrimination included having their illness treated dismissively or being shown a lack of understanding about how mental health problems affect behaviour and work performance. Other common experiences included being forced to change responsibilities or being denied opportunities, being fired or made redundant and

being judged or treated as incompetent. Concern about such issues has led to the development in many countries of anti-stigma interventions and campaigns that seek to address these issues. These include beyondblue's Heads Up program in Australia (https://www.headsup.org.au/), Time to Change in the UK (Henderson, Williams, Little, & Thornicroft, 2013) and Opening Minds in Canada (Mental Health Commission of Canada, 2013). A recent review of workplace anti-stigma interventions found that effects on knowledge, attitudes and behaviours were mixed, but generally positive (Hanisch et al., 2016).

The findings from the analysis of responses from those who reported supportive experiences highlight the importance of promoting positive actions rather than focusing on what people in the workplace must not do. Among the 25% of people reporting more positive treatment, the most common experiences were being given flexibility with duties or hours worked, being allowed time off, having colleagues increase contact or check in with them to see how they were going, having someone at work be willing to listen to the respondent talk about their issues and encouragement to seek professional help. While some businesses have less flexibility than others, the results of the study may be helpful in providing guidance to employers of people with mental health problems. Similar themes emerged from the analysis of experiences of those in education settings, with the most common supportive experiences being those relating to special consideration and non-specific support. Lack of understanding and a reluctance to be flexible about tasks were the most common discriminatory experiences, pointing to the need to improve mental health literacy of teachers and lecturers, particularly in the context of the high prevalence rates of mental health problems in young people (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010).

The prevalence estimates are somewhat lower than those seen in a Canadian survey that asked respondents who had been treated for a mental illness in the past year about unfair treatment (Stuart et al., 2014), possibly due to differences in sampling. Twenty-eight percent of people reported this in relation to school or work life. In a 35-country survey of people with major

depressive disorder attending specialist mental health services, Lasalvia et al. (2013) found that 21% reported discrimination in the area of keeping a job, 13% in finding a job and 12% in education. In a similar study with people with schizophrenia, 29% of people reported discrimination in the area of keeping a job and 29% in finding a job, while 19% reported difficulty in education (Thornicroft et al., 2009).

The study has several strengths. As respondents included people who are not in contact with mental health services, the results are less likely to be biased towards under-reporting if people who experienced very high levels of discrimination avoided service contact and therefore were not included in other surveys that have sampled service users. (Lasalvia et al., 2013). There is also less likely to be bias towards over-reporting due to people who have experienced discrimination being more likely to volunteer to take part in a survey on the topic. Moreover, the findings were corroborated by report of others, suggesting that the personal reports of discrimination are less likely to be due to distorted perceptions. Limitations of the study include the relatively low response rate of 37% which, while in line with other similar Australian surveys, may limit the generalisability of the results (Curtin, Presser, & Singer, 2005). The short responses also did not allow for a deeper investigation of the context in which discrimination or support is experienced and further qualitative research may be useful in elucidating this.

It is hoped that the results of the current study can provide much-needed input into the design of anti-discrimination interventions, particularly for people with mental health problems who are looking for work. This may include supporting people with mental illness to overcome anticipated discrimination (Thornicroft et al., 2009) and education of employers to support stigma reduction (Henderson et al., 2013). Further work is needed to explore the factors predicting workplace discrimination and positive treatment in order to best promote the latter.

References

Amarasuriya, S. D., Jorm, A. F., Reavley, N. J., & Mackinnon, A. J. (2015). Stigmatising attitudes of undergraduates towards their peers with depression: a cross-sectional study in Sri Lanka. *BMC Psychiatry, 15*, 129. doi: 10.1186/s12888-015-0523-9

Andrews, B., & Wilding, J. M. (2004). The relation of depression and anxiety to life-stress and achievement in students. *British Journal of Psychology, 95*, 509-521.

Australian Bureau of Statistics. (2012). National Health Survey 2011-12. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2014a). ABS Census 2011 Table Builder, from http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240

Australian Bureau of Statistics. (2014b). Estimated Resident Population March 2014. Canberra: Australian Bureau of Statistics,.

Australian Communication and Media Authority. (2014). Communications report 2013–14. Canberra: Australian Communication and Media Authority.

Baldwin, M. L., & Marcus, S. C. (2006). Perceived and measured stigma among workers with serious mental illness. *Psychiatric Services, 57*, 388-392. doi: 10.1176/appi.ps.57.3.388

Brohan, E., Henderson, C., Little, K., & Thornicroft, G. (2010). Employees with mental health problems: Survey of U.K. employers' knowledge, attitudes and workplace practices. *Epidemiologia e Psichiatria Sociale, 19*, 326-332.

Corrigan, P. W., Larson, J. E., & Rusch, N. (2009). Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World Psychiatry, 8*, 75-81.

Curtin, R., Presser, S., & Singer, E. (2005). Changes in telephone survey non-response over the past quarter century. *Public Opinion Quarterly, 69*, 87-98.

Hanisch, S. E., Twomey, C. D., Szeto, A. C., Birner, U. W., Nowak, D., & Sabariego, C. (2016). The

effectiveness of interventions targeting the stigma of mental illness at the workplace: a

systematic review. *BMC Psychiatry, 16*, 1. doi: 10.1186/s12888-015-0706-4

Henderson, C., Williams, P., Little, K., & Thornicroft, G. (2013). Mental health problems in the

workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010.

[Research Support, Non-U.S. Gov't]. *British Journal of Psychiatry. Supplement, 55*, s70-76.

doi: 10.1192/bjp.bp.112.112938

Holborn, A. T., Reavley, N. J., & Jorm, A. F. (2012). Differences between landline and mobile-only

respondents in a dualframe mental health literacy survey. *Aust NZ J Public Health, 36*, 192-

193.

Hu, S. S., Balluz, L., Battaglia, M. P., & Frankel, M. R. (2011). Improving public health surveillance

using a dual-frame survey of landline and cell phone numbers. *American Journal of

Epidemiology, 173*, 703-711. doi: kwq442 [pii] 10.1093/aje/kwq442

Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005). The impact of depression on the academic

productivity of university students. *Journal of Mental Health Policy and Economics, 8*, 145-

151.

Jorm, A. F., Kitchener, B. A., Sawyer, M. G., Scales, H., & Cvetkovski, S. (2010). Mental health first aid

training for high school teachers: a cluster randomized trial. *BMC Psychiatry, 10*, 51. doi:

1471-244X-10-51 [pii] 10.1186/1471-244X-10-51

Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric

disorders, I: Educational attainment. *American Journal of Psychiatry, 152*, 1026-1032.

Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., Furukawa, T. A.,

Gureje, O., Hinkov, H., Hu, C. Y., Lara, C., Lee, S., Mneimneh, Z., Myer, L., Oakley-Browne, M.,

Posada-Villa, J., Sagar, R., Viana, M. C., & Zaslavsky, A. M. (2010). Screening for serious

mental illness in the general population with the K6 screening scale: results from the WHO

World Mental Health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research, 19 Suppl 1*, 4-22. doi: 10.1002/mpr.310

Kessler, R. C., Heeringa, S., Lakoma, M. D., Petukhova, M., Rupp, A. E., Schoenbaum, M., Wang, P. S., & Zaslavsky, A. M. (2008). Individual and societal effects of mental disorders on earnings in the United States: results from the national comorbidity survey replication. *American Journal of Psychiatry, 165*, 703-711. doi: 10.1176/appi.ajp.2008.08010126

LaMontagne, A. D., Keegel, T., Louie, A. M., & Ostry, A. (2010). Job stress as a preventable upstream determinant of common mental disorders: A review for practitioners and policy-makers. *Advances in Mental Health, 9*, 17-35.

Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., Bacle, S. V., Van Audenhove, C., van Weeghel, J., Reneses, B., Germanavicius, A., Economou, M., Lanfredi, M., Ando, S., Sartorius, N., Lopez-Ibor, J. J., & Thornicroft, G. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. [Research Support, Non-U.S. Gov't]. *Lancet, 381*, 55-62. doi: 10.1016/S0140-6736(12)61379-8

Levinson, D., Lakoma, M. D., Petukhova, M., Schoenbaum, M., Zaslavsky, A. M., Angermeyer, M., Borges, G., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Haro, J. M., Hu, C., Karam, A. N., Kawakami, N., Lee, S., Lepine, J. P., Browne, M. O., Okoliyski, M., Posada-Villa, J., Sagar, R., Viana, M. C., Williams, D. R., & Kessler, R. C. (2010). Associations of serious mental illness with earnings: results from the WHO World Mental Health surveys. *British Journal of Psychiatry, 197*, 114-121. doi: 10.1192/bjp.bp.109.073635

Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177-190.

Little, K., Henderson, C., Brohan, E., & Thornicroft, G. (2011). Employers' attitudes to people with

    mental health problems in the workplace in Britain: changes between 2006 and 2009.

    Epidemiol Psychiatr Sci, 20, 73-81.

McDowell, C., & Fossey, E. (2015). Workplace accommodations for people with mental illness: a

    scoping review. *Journal of Occupational Rehabilitation, 25*, 197-206. doi: 10.1007/s10926-

    014-9512-y

Mental Health Commission of Canada. (2013). Opening Minds Interim Report. Calgary: Mental

    Health Commission of Canada.

Reavley, N. J., & Jorm, A. F. (2011). Young people's stigmatizing attitudes towards people with

    mental disorders: findings from an Australian national survey. *Australian and New Zealand*

    Journal of Psychiatry, 45, 1033-1039. doi: 10.3109/00048674.2011.614216

Reavley, N. J., & Jorm, A. F. (2015). Experiences of discrimination and positive treatment in people

    with mental health problems: Findings from an Australian national survey. *Australian and*

    New Zealand Journal of Psychiatry, 49, 906-913.

Reavley, N. J., Ross, A. M., Killackey, E., & Jorm, A. F. (2013). Development of guidelines for tertiary

    education institutions to assist them in supporting students with a mental illness: a Delphi

    consensus study with Australian professionals and consumers. *PeerJ, 1*, e43. doi:

    10.7717/peerj.43

Rutman, I. D. (1994). How psychiatric disability expresses itself as a barrier to employment.

    Psychosocial Rehabilitation Journal, 17, 15-35.

Stuart, H., Patten, S. B., Koller, M., Modgill, G., & Liinamaa, T. (2014). Stigma in Canada: results from

    a rapid response survey. *Canadian Journal of Psychiatry, 59*, S27-33.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced

    and anticipated discrimination against people with schizophrenia: a cross-sectional survey.

    Lancet, 373, 408-415. doi: 10.1016/S0140-6736(08)61817-6

Viering, S., Bartsch, B., Obermann, C., Rusch, N., Rossler, W., & Kawohl, W. (2013). The effectiveness

of individual placement and support for people with mental illness new on social benefits: a

study protocol. *BMC Psychiatry, 13*, 195. doi: 10.1186/1471-244X-13-195

Wagner, S. L., Koehn, C., White, M. I., Harder, H. G., Schultz, I. Z., Williams-Whitt, K., Warje, O.,

Dionne, C. E., Koehoorn, M., Pasca, R., Hsu, V., McGuire, L., Schulz, W., Kube, D., & Wright,

M. D. (2016). Mental Health Interventions in the Workplace and Work Outcomes: A Best-

Evidence Synthesis of Systematic Reviews. *Int J Occup Environ Med, 7*, 1-14.

Wilkinson, R. G., & Marmot, M. (Eds.). (2003). *Social determinants of Health: The Solid Facts*.

Geneva: World Health Organisation.

Tables

Table 1 Clinical and sociodemographic characteristics of respondents classified as having a mental health problem

	Weighted %
Mental health problem[a]	
Depression	55.6
Anxiety (including PTSD,	
OCD)	45.2
Bipolar disorder	4.6
Psychotic disorder	2.7
Eating disorder	2.3
Personality disorder	1.2
Age category	
18-29 years	29.2
30-59 years	58.0

60+ years	12.8
Female	56.4

Marital status

Never married	34.8
Married or defacto	49.2
Separated, divorced or widowed	16.0

Highest level of education

Below bachelor level	79.8
Bachelor degree or above	20.2
Aboriginal or Torres Strait Islander	4.7

Country of birth

Australia	81.3
Other	18.7

Language spoken at home

English	86.2
Other	13.8

a Multiple diagnoses were possible

Table 2 Experiences of discrimination and positive treatment by people in the workplace or place of education over previous 12 months

	Experiences reported by people with mental health problems % (95% CI)	Experiences reported by people who knew another adult with mental health problems % (95% CI)
People in the workplace	*(n=992)*	*(n=1665)*
Avoided	11.3 (9.0-14.1)	11.6 (10.0-13.5)
Discriminated	13.9 (11.4-16.9)	13.6 (11.8-15.6)
Treated more positively	24.4 (21.3-27.7)	21.4 (19.1-23.8)
Looking for work	*(n=410)*	*(n=729)*
Discriminated	10.4 (7.1-14.9)	17.5 (14.2-21.3)
Treated more positively	6.5 (4.1-10.1)	6.6 (4.6-9.4)
Education	*(n=317)*	*(n=457)*
Avoided	5.6 (3.2-9.8)	7.5 (5.1-10.9)
Discriminated	7.1 (4.6-11.0)	7.8 (5.5-11.0)
Treated more positively	31.4 (25.7-37.8)	30.8 (25.9-36.1)