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Last Bastion Nevermore! A Qualitative Exploration of the Australian Government's Fifth National Mental Health and Suicide Prevention Plan from the Perspective of Lessening Mental Stigma and Sanism in the Workplace

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ABSTRACT *The need to advance mental health through greater levels of social and economic inclusion represents a pressing policy issue. Within Australia, this policy focus has been progressed at a national level. This exploratory study aims to critically investigate The Fifth National Mental Health and Suicide Prevention Plan in terms of its potential to help reduce mental stigma and discrimination within Australian workplaces. Qualitative content analysis was applied to the national policy document as well as to 12 academic texts retrieved from a Google Scholar search and meeting inclusion criteria. Stage one of the content analysis process revealed themes of representation, education, research, and activism, while stage two added those of language, legal, and media. This study posits that workplace anti-mental stigma and sanism measures as identified within the Plan are limited in the sense that they represent only a subset of those currently available. This research also supports the prospect of these measures operating in a collaborative manner. Finally, it is proposed that potential exists throughout Australian workplaces to implement stigma and sanism reduction measures that specifically target the health and peer workforce.*

KEYWORDS neurodiversity; sanism; stigma; mental health policy; Australian Government

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Sanism Overview, Social Prevalence and Ideological Influence

Sanism has been defined as "the irrational prejudice associated with mental illness, rooted in stereotypes, myths, superstition, and deindividualisation" (Perlin, 2003, cited in Williams, 2014, p. 12). The term was devised by Dr. Morton Birnbaum who is known for advancing treatment rights for mental health patients (Perlin, 2003). It is prudent to recognise that sanism varies in terms of its forms, oppressions and impacts. While sanism might involve obvious discrimination, it will tend to be reflected in microaggressions (i.e., numerous small-scale slights and humiliations) (Kalinowski & Risser, 2005, cited in Poole et al., 2012). Sanism normalises labelling and banishment as well as the practices that enable a removal of identity (Poole, 2013, cited in Meerai, Abdillahi & Poole, 2016,). According to LeFrancois and Coppock (2014), sanism might involve lived experiences of hostility, stereotyping and prejudice. Leblanc and Kinsella (2016) depict sanism in terms of marginalising the understandings of neurodiverse individuals and adding to epistemic injustice. Epistemic injustice constricts those persons considered as deficient in credibility (Carver, Morley & Taylor, 2017). Pertaining to human rights and the law, Perlin (1999) too cautions that sanism can contaminate legal practices. Intersectionality as it relates to sanism involves further kinds of social discrimination including racism and colonialism (Burstow, LeFrancois & Diamond, 2014, cited in Nicki, 2015). Referring to the intersection of racism and sanism, Meerai, Abdillahi and Poole (2016, p. 23) position anti-Black sanism in terms of how identity can be "stripped away" and confronted by white interests. Moreover, colonialism, "as a breeding ground for the fundamental discourses of differences," has spawned concepts of national identity, madness and sanism (Joseph, 2016, p. 40). The rise, expansion and dominance of sanist biomedical ideology owes much to colonialism. To this end, Kurchina-Tyson (2017) recognises that the authoritarian practice of psychiatry, as established upon colonialism, frames its ideological underpinnings as normal and indispensable.

Sanism survives via society's patience for it (Procknow, 2017). With sanism now socially entrenched (Large & Ryan, 2012), Morrow and Weisser (2012, p. 40) describe discrimination towards the mentally unwell as "systemic." The medical model of disability reinforces this undesirable status quo. Kriegler (2015) cautions that medicalisation inspires clinical answers while overlooking or toning down the social background of complex struggles. Furthermore, clinicians, philosophers and bioethicists exist who see disability as being fundamentally negative states that people endure (Guidry-Grimes, 2017). In the words of Williams (2014, p. 3), "sanism, it seems, offers the last bastion of acceptable prejudice." Nevertheless, sanism cannot lay claim to be without ideological opposition. In addition to the need to address prejudices of racism, ageism and sexism, Large and Ryan (2012) also call for efforts to battle sanism. Mad Studies represent one form of this resistance. Castrodale (2017) note that Mad

Studies signify a progressing field where Mad academics frequently strive to unsettle prevailing mental health discourses. Emerging from Canadian critical disability scholarly work, Mad Studies offer persuasive and uniting opposition to biomedical ideology (LeFrancois, Beresford & Russo, 2016). Furthermore, Poole et al. (2012) recognise that the social model of disability offers possibilities for anti-sanism communication. This model thus represents an ideological alternative to the traditional medical model.

Stigma, Sanism and Australian Workplaces

The term "neurodiversity" offers a progressive alternative to medical model endorsed labelling of people as "mentally ill". Neurodiversity is defined as, "the range of differences in individual brain function and behavioural traits" (Oxford University Press, 2018). This contrasts with the term "neurotypical" which is defined in relation to "having normal brain activity" (Collins English Dictionary, 2018). Having originally appeared in an article written in the late 1990s concerning autism prevalence within Silicon Valley, the term of neurodiversity was to become a flag for the autistic self-advocacy movement (Blume, 1998, cited in Liu, 2017). However, the evolving nature of this term should be recognised. Graby (2015) advises that recently, the neurodiversity movement has enlarged its representation of persons with mental conditions.

It is appropriate that citizens who identify as neurodiverse are socially and economically included within Australian society. However, attaining this inclusion is not straightforward. Armstrong and Dorsett (2015) caution that a route to accomplishing a confident future for individuals who are undergoing mental health difficulties can on occasions appear to be unattainable. Stigma should be considered among the factors which can hinder the prospects of neurodiverse persons. Williams (2014) adds that it is broadly recognised that stigma provides a foundation for discrimination, separation and social rejection. Oakley (2017) describes stigma about mental ill health as a major concern that should be attended to throughout Australian workplaces and industries. Evidence supports this position. In an Australian mental illness survey, 53% of participants reported having experienced stigma in the workplace (SANE Australia, 2011, cited in SANE Australia 2013, p. 9). Furthermore, a study of Australian employees involving 1,126 interviews revealed that around one-third of respondents had issues related to working with someone who has anxiety or depression, with the same percentage of respondents also perceiving that these persons could not satisfactorily undertake their roles (TNS Social Research, 2014, p. 5). Reporting on an Australian study that was informed by in-depth

interviews with 13 lived experience practitioners,[1] Byrne, Roper, Happell and Reid-Searl (2016) reveal that participants, especially those within government establishments, reported professional seclusion as well as being treated differently. Moreover, Bennetts, Pinches, Paluch and Fossey (2013) recognise that consumers seldom hold powerful positions within the area of mental health. Stigma can also influence plans to seek help (Wynaden, Chapman, Orb, McGowan, Yeak, & Zeeman, 2005, cited in Wynaden et al., 2014). Research involving 201 students and 270 staff members from two Australian universities reveals a theme of "silence" around mental health challenges (Wynaden et al., 2014, p. 341). Such silence may work to undermine the efforts of policymakers and practitioners to make Australian workplaces more inclusive of neurodiversity. Positioning sanism in relation to stigma, Poole et al. (2012, p. 25) state, "the over-arching, prevalent, and often ignored oppression known as sanism is to blame for 'breeding' stigma and our continued interest in it as educators, researchers, and practitioners." Complicating matters, as sanism yields stigma and stigma brings about sanism, it has been argued that discriminatory behaviour and prejudicial viewpoints are components of stigma as well as sanism (Parry, 2009, cited in Williams, 2014). Further, Thornicroft, Rose, Kassam and Sartorius (2007, p. 192) contend that stigma encompasses three connected components of prejudice, ignorance, and discrimination. Nevertheless, while agreeing that stigma might bring about discrimination, Large and Ryan (2012) also posit that discrimination via prejudice (i.e., through the "isms") is more common and identifiable. Intersecting with colonialism, Poole et al. (2012, p. 21; Sayce, 1998), reinforce the need to look beyond stigma, as this concept preserves medical discourse about "mental health" while also minimising the oppression (i.e., sanism) as experienced by persons with histories of mental conditions. Furthermore, it is appropriate to recognise that sanism is being redressed through expanding legal protections. To this end, Perlin (2013a) reports that law reform is demanded by the Convention on the Rights of Persons with Disabilities on an international scale.

The Fifth National Mental Health and Suicide Prevention Plan

The need to advance mental health through a greater social and economic inclusion of neurodiverse citizens is a pressing policy issue. Within Australia, this mental health policy focus has been advanced at a national level. The National Mental Health Commission (2017) suggests that once finalised, the Fifth National Mental Health Plan will form a foundation for continued national tracking of mental health results and reform advancement. However, instances exist of public commentary in relation to

[1] "Lived experience practitioner" is a broad term that captures the range of mental health service work roles as conducted by persons with lived experience (Byrne et al., 2016).

the draft Plan that is critical of early policy direction. Rosenberg (2016) suggests that the Plan, while succeeding at "buzzword bingo," does not elaborate on how national tactics transform into regional, community and personal action. Baxendale (2016) also reports,

> John Mendoza said the plan, which is a collaboration between state, territory and federal governments, was the work of bureaucrats with no institutional knowledge and sought to continue a flawed scheme of funding costly late-term intervention at the expense of prevention and early intervention.

Being cognisant of these criticisms, the Australian Government has recently released the finalised policy document entitled, The Fifth National Mental Health and Suicide Prevention Plan (subsequently to be referred to as "the Plan"), with the stated aim to "reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community" (Commonwealth of Australia, 2017, p. 2). The purpose of this paper is to critically investigate the potential for this new national policy to help reduce instances of mental stigma and sanism within Australian workplaces.

Methods

This study has been guided by the approach to conducting qualitative content analysis as espoused by Zhang and Wildemuth (2009). Such analysis was completed over two stages. These two levels of analysis enabled a comparison of the Plan to the associated scholarly literature in order to: (a) assess the adequacy of the Plan; (b) suggest additional themes from the literature that should be addressed in the Plan; and (c) suggest ways for themes mentioned in the Plan to be better implemented. Stage one focused analysis on the Plan itself. Steps included: (a) setting the unit of analysis as sentences or paragraphs; (b) creating a coding system encompassing themes and their coding rules; (c) testing the coding system against a sample of text; (d) coding the remaining text; (e) testing for coding consistency; (f) drawing implications from the coded text; and (g) reporting findings. Themes representing various measures with potential to reduce mental stigma and/or sanism in Australian workplaces, their coding rules and supporting quotes were recorded in an analytical table. Such themes were identified under the Plan's Priority Area 6: Reducing Stigma and Discrimination section (Commonwealth of Australia, 2017, p. 40). In order to meet the study's aim of undertaking a critical policy investigation, anti-mental stigma and discrimination in the workplace themes as identified in the Plan were compared against those identified from scholarly literature. Stage two of the analysis process thus involved the content analysis of these scholarly texts with results (i.e., themes, coding rules and supporting quotes) recorded in a second analytical table. Enabling this comparison of the Plan

to the associated literature in order to critically assess its adequacy and to inform improvements, a purposive sample of academic texts was constructed. These publications were identified via a Google Scholar search of recently published documents (i.e., since 2013) and applying the search term: "sanism" AND workplace." This time period and search term were deemed appropriate in establishing a sample which could offer contemporary and insightful findings. Document inclusion criteria were applied as follows: document type = journal article OR thesis; AND text contains measures(s) with potential to reduce mental stigma and/or sanism in the workplace; AND text is accessible; AND no duplicates.

Results

Stage one of the content analysis process produced four anti-mental stigma and/or anti-sanism in the workplace themes. Promoting research transparency and reliability, themes including those of "representation," "education," "research," and "activism," along with their coding rules and supporting quotes are provided in Table 1. The Google Scholar search produced a total of 77 possibly relevant texts. Of these texts, 12 were identified as relevant after applying the inclusion criteria. Themes, coding rules and supporting quotes as recorded in stage two of the content analysis process are provided in Table 2. This second table, which includes each of the four themes identified in Table 1, adds those of "language," "legal," and "media."

Theme & Coding Rule	**Supporting Quotations**
Representation Aims to reduce mental stigma via workplace representation.	"developing and implementing training programs that build awareness of and knowledge about the impact of stigma and discrimination" (Commonwealth of Australia, 2017, p. 40). "The Mental Health First Aid training has been shown to decrease negative attitudes and increase supportive behaviours towards people living with mental illness" (Hadlaczky, Hökby, Mkrtchian, Carli & Wasserman, 2014, cited in Commonwealth of Australia, 2017, p. 40).
Education Aims to reduce mental stigma and discrimination via workplace education.	"developing and implementing training programs that build awareness of and knowledge about the impact of stigma and discrimination" (Commonwealth of Australia, 2017, p. 40). "The Mental Health First Aid training has been shown to decrease negative attitudes and increase supportive behaviours towards people living with mental illness" (Hadlaczky et al., 2014, cited in Commonwealth of Australia, 2017, p. 40).
Activism Aims to reduce mental stigma and discrimination via various forms of resistance and alliances.	"responding proactively and providing leadership when stigma or discrimination is seen" (Commonwealth of Australia, 2017, p. 40). "empowering consumers and carers to speak about the impacts of stigma and discrimination" (Commonwealth of Australia, 2017, p. 40). "involve consumers and carers, community groups and other key organisations" (Commonwealth of Australia, 2017, p. 40).
Research Aims to reduce mental stigma and discrimination via research initiatives.	"build on existing initiatives, including the evidence base of what works in relation to reducing stigma and discrimination" (Commonwealth of Australia, 2017, p. 40). "identify effective anti-stigma interventions with the health workforce" (Commonwealth of Australia, 2017, p. 40).

Table 1. Anti-mental stigma/sanism workplace themes derived through content analysis of the Fifth National Mental Health & Suicide Prevention Plan.

Theme & Coding Rule	Supporting Quotations
Representation Aims to reduce mental stigma and sanism through greater representation of employees with neurodiversity.	"The suggestion by participants that more lived experience roles are needed to counter isolation and challenge 'stigma thinking' within organisations, is supported by studies emphasising the benefits of networking and of having more than one lived experience practitioner within services" (Bennetts, Pinches, Paluch, & Fossey, 2013, cited in Byrne et al., 2016, p. 5; Moran, Russinova, Gidugu, Yim, & Sprague, 2012). "lived experience practitioners can potentially play a vital role in lessening stigma and discrimination" (Byrne et al. 2016, p. 6). "Indeed, it is presumably much easier to be out and comfortable when one is not isolated or tokenized in the workplace" (Pilling, 2014, p. 259).
Language Aims to reduce sanism through discourse.	"These authors argue for the need to highlight prejudice inherent in attitudes: demonstrated by terms like mentalism (Chamberlain, 1978) and sanism (Perlin, 2013)" (Byrne et al., 2016, p. 4). "Use of such terms may result in greater awareness and sensitisation to presently taken for granted prejudicial attitudes against people experiencing mental distress" (Byrne et al., 2016, p. 4). "Neurotypicals tap our 'mad' lexicon e.g., 'that was crazy' or 'insane,' without reflecting on the pathological connotations of these words" (Ingram, 2011, cited in Procknow, 2017, p. 6).
Legal Aims to reduce sanism through legal reforms.	"Nonhumiliation means that equitable courts should take American workers' mental suffering seriously enough to credit the documentation of their suffering, that courts should hear such workers' stories, and that such workers should not be treated as malingerers" (Rudolf, 2017, p. 134). "According to Brohan et al. (2012), the concern of being stigmatized as a result of disclosure specifically involves several key fears, including not being hired, unfair treatment in the workplace, or being unprotected by existing legislation" (Suleiman, 2017, p. 48). "Legal decision-makers commonly base their decisions on stereotypical presumptions, heuristic reasoning and a process of balancing and weighing moral values and principles" (Williams, 2014, pp. 254-255). "Persons should also have access to complaints mechanisms in cases of human rights violations" (Aytenew, 2012, p. 123).

Media Aims to reduce mental stigma and sanism via media.	"The government should work to change attitudes and raise awareness towards mental disabilities though print and broadcast media and different forms of public mobilization" (Aytenew, 2012, p. 122). "The I Got Better campaign 'aims to challenge the dominant narrative of hopelessness in mental health care by making stories of hope and mental wellness widely available through a variety of media'" (Mindfreedom International, n.d., cited in Guidry-Grimes, 2017, p. 14).
Education Aims to reduce mental stigma and sanism through workplace education.	"Participants also talked at length about different conceptualizations of mental health, challenging those informed by the dominant narrative, and sharing and developing alternative knowledge" (Martin-Calero Medrano, 2016, p. 192). "HR's embodied, exalted ignorance on depression within eight Australian IT firms was found to have tacitly endorsed the disenfranchisement of depressed employees" (Davies, 2006, cited in Procknow, 2017, p. 16). "An opportunity exists within social work education to stop stigma and sanism, while promoting mental health and well-being across our profession" (Singh, 2016, p. 96).
Activism Aims to reduce sanism through various forms of resistance and alliances.	"She went on to emphasize the importance of employers who are invested in 'putting people over making a profit' and encouraging employees to 'talk candidly' about mental health and respond with understanding'" (Pilling, 2014, p. 260). "a narrative of resistance involves regaining voice, constructing an alternative body of knowledge, and finding and connecting with likeminded others" (Martin-Calero Medrano, 2016, p. 191). "Silence begets sanism" (Procknow, 2017, p. 18). "Progressive changes in law and policy over the past century have relied critically on identity-based social movements, and they will likely continue to do so" (Wendell, 2013, p. 49).

Research Aims to reduce mental stigma and sanism through research initiatives.	"there is a need to develop an alternative body of knowledge and making it accessible for MHWHs, so that we are not on our own in questioning and challenging dominant mental health conceptualizations" (Martin-Calero Medrano, 2016, p. 193). "Qualitative research could explore how employees with mental, physical, and cognitive disabilities cope with stigma and discrimination differently, how coworkers treat them differently based on the disability, and how workplaces can be more productive when people with different disabilities are accommodated correctly" (Procknow & Rocco, 2016, p. 396). "It is important that public understanding and social policies regarding stigma are informed by the research" (Williams, 2014, p. 139).

Table 2. Anti-stigma/sanism workplace themes derived from content analysis of journal articles searched via Google Scholar.

Discussion: Anti-Sanism in the Workplace Themes

This section critically discusses each of the themes derived from the two stages of content analysis. Based on evidence derived from the Plan as well as the scholarly literature, measures will be described in terms of their capacity to redress mental stigma, sanism (or both) in the workplace. Gaps in measure potential will also be highlighted, while possible collaborations between measures will be emphasised. Topics of intersectionality as related to sanism will also be addressed.

Representation

Specifically targeting mental stigma, the Plan includes a measure supporting purposeful contact between peer workers and mental health stakeholders (Commonwealth of Australia, 2017). Such policy direction is supported by research. More generally, contact has been identified as a useful anti-stigma strategy (Corrigan & Penn, 1999, cited in Williams, 2014). Consideration should therefore be given to expanding the scope of this measure with the goal of encouraging greater interaction among neurodiverse and neurotypical employees across Australian workplaces. It should, however, be realised that policy efforts to encourage this closer contact can face significant barriers. One notable obstacle is that of negative stereotypes. As Williams (2014) points out, misunderstandings and anxieties offer rich ground for spreading stigma. In this way, "normal" persons tend to see people with disabilities as being less intelligent and

conscientious (Lengnick-Hall, Gaunt & Kulkarni, 2008, cited in Procknow & Rocco, 2016). Crucially, the stereotyping of disability need not go unchallenged. To this end, Byrne et al. (2016, p. 1) citing Ahmed, Hunter, Mabe, Tucker & Buckley (2015) and Warner (2010) state:

> Within mental health settings, people are employed to work specifically from their lived experience of mental health challenges to help improve service quality, challenge discriminatory attitudes, advocate and be an inspiration for those currently accessing services.

The Plan limits the role of a greater representation of neurodiverse persons to that of fighting mental stigma. However, scholarly literature supports a broader application of this measure. In addition to challenging stigma, Byrne et al. (2016) position more lived experience practitioners as helpful to countering discrimination (i.e., oppression through isolation). It is thus conceivable that having greater numbers of neurodiverse individuals participating in the mental health workforce as well as across Australian workplaces more widely might help to resist both stigma and sanism. Nonetheless, Australians who are employed on the basis of their work experience and qualifications, as well as their lived experience with neurodiversity, should not feel that they have to be a source of motivation to service users or to anyone else.

Language

Recognising an intersection between the "isms" of sanism and colonialism, it is important that national mental health policy does not overlook language as a contributor to workplace sanism. The potential of language to assist in lessening sanism is recognised within the scholarly literature. According to Williams (2014) there is a drought of public discussion concerning the indecency of sanist discourse. Procknow (2017, p. 6) citing Ingram (2011) also warns, "neurotypicals tap our 'mad' lexicon e.g., 'that was crazy' or 'insane', without reflecting on the pathological connotations of these words." A hegemonic state may thus be envisaged whereby discourse acts to cement the disempowerment of neurodiverse employees. Crucially, this oppressive state is not inevitable. Government officers, through their mental health policy development and implementation activities, should endeavour to disrupt sanist discourse within organisational and other settings. Moving away from the sanist influences of colonialism, these officers should instead endorse language that is compatible with principles of diversity and inclusion. However, in the interests of practically reducing sanism in Australian workplaces, a broad dissemination of inclusive discourse is not enough. Williams (2014) describes the situation whereby politically appropriate discourse can create a sense that prejudice is being addressed when really there tends to be not

much in the way of positive transformation experienced. It is therefore appropriate for national mental health policy to also support the widespread monitoring of workplace behaviours with the goal of encouraging these to be compatible with progressive discourse that values and respects mental diversity. Through recognising potential synergies that might exist between themes, the prospect of a legal policy instrument encouraging this desired shift towards more respectful and socially inclusive discourse throughout Australian workplaces is discussed as follows.

Legal

The Plan in its current state overlooks the legal policy instrument in the fight against sanism. This oversight is significant as workplace sanism is conceivably encouraged through: (a) gaps in legislation; (b) failure to protect employees under current laws following their disclosure of neurodiversity; and (c) ideological resistance attempting to deny neurodiverse staff access to the reasonable accommodations to which they are legally entitled (where these adjustments are required and sought). Starting with gaps in disability legislation and linking back to the previous theme, Williams (2014, p. 180) cautions "racist language is considered legally offensive language while sanist language is socially, and therefore, legally acceptable language." Hence, mental health policymakers should widely consult with disability stakeholders and investigate the level of support available for a juxtaposition of sanist language alongside other forms of lawfully offensive discourse. Still, it should be remembered that the legislative policy instrument once implemented is not a panacea for sanism. Anxiety about becoming stigmatised following disclosure of disability can include the fear of missing out on protection under current laws (Brohan et al., 2012, cited in Sulieman, 2017). Intersectionality, in the form of oppression and epistemic injustice, is thus not easily severed. Moreover, having disclosed neurodiversity, traditional ideology can attempt to restrict employee access to reasonable adjustments in the workplace. Under the persisting influence of colonialism, Guidry-Grimes (2017) notes that biomedical models position disability as always threatening functional capacity despite the accommodations availed. Potential implications of such ideological resistance towards advancing inclusive workplaces should not be understated. Citing Rocco (1999), Procknow and Rocco (2016, p. 389) comment, "participants with invisible disabilities recalled losing a job due to their disability by unlawful termination, being denied accommodations, and/or having to withdraw from the workplace to deal with disability-related depression." A need exists to better advance the legal rights of existing and prospective employees who identify as neurodiverse. This includes the right to disclose neurodiversity without experiencing discrimination and to be reasonably accommodated wherever needed. This

legal dimension warrants particular attention by the Australian Government in future mental health policy development efforts.

Media

The Plan fails to explicitly mention media reform among its suite of actionable measures to reduce mental stigma and discrimination. This topic is important as the media frequently applies excessive interest to the uncommon occasions where people with mental disabilities perform a violent offence (Smith, 1997, cited in Aytenew, 2012, p. 29). Moreover, media influence in strengthening the intersectionality between sanism and racism should not be discounted. Hence, a requirement exists for future research to investigate the possible level to which unethical reporting is feeding anti-Black sanism. Scholarly attention is also required to identify less obvious media cases through which colonialism-sanctioned oppression is promoted. For example, Guidry Grimes (2017, p. 14) citing Mindfreedom International (n.d.) states, "the I Got Better campaign 'aims to challenge the dominant narrative of hopelessness in mental health care by making stories of hope and mental wellness widely available through a variety of media'." On the surface, this message about achieving mental health might appear to be empowering and uplifting. However, one does not have to dig too deep to uncover traditional ideological constructions of disability. Pilling (2014) explains that the biomedical model is the prevailing way of visualising mental difficulties within the media. However, medical model endorsed meanings overlook the possibility of individuals not wanting to be cured or relieved from their lived experiences with neurodiversity. The media is instead challenged to construct messages that promote the benefits and inclusion of neurodiversity in the workplace as well as elsewhere across Australian society. Such a progressive shift in policy direction endeavours to advance ethical media coverage of mental diversity by identifying and challenging those clinically endorsed messages which hold potential to stigmatise, disempower and exclude.

Education

The Plan sees training as assisting to lower stigma and discrimination within the health workforce (Commonwealth of Australia, 2017). Such education is vital, as Guidry-Grimes (2017) notes that fear along with separation are often faced by persons who are experiencing psychiatric disabilities. Literature too supports the application of education as a valuable tool for redressing both mental stigma and sanism (Singh, 2016). To this end, diversity education that encompasses material about disability can progress acceptance, reduce prejudice and diminish "toxic" stereotypes

(Boyle, 1997, cited in Procknow & Rocco, 2016, p. 392; Rocco, 1999). Noting this potential, it would nevertheless be premature to celebrate education as an easy solution to attaining a greater inclusion of neurodiverse employees. In this regard, supervisors and human resource personnel have reported uneasiness on the subject of mental ill health (Procknow, 2017 referencing Davies, 2008). Research is thus needed to examine the possible extent to which workplaces might be failing neurodiverse employees by either: (a) not providing human resource professionals, managers and others in the workplace with mandatory mental diversity awareness training; or (b) providing such training only to have this education be ineffective. It should also be remembered that while education as an anti-stigma measure can deliver positive outcomes, connection with a person who is experiencing mental health challenges can provide even better results (Corrigan et al., 2002, cited in Williams, 2014). Linking back to the representation theme, consideration should therefore be given to having neurodiverse employees take a lead role in delivering mental diversity awareness sessions. It is within these sessions where mentally diverse individuals can be given opportunities to share their stories with colleagues and to also challenge the oppression and discrimination that is steeped in colonialism. Importantly, neurodiverse employees should not feel obliged or pressured in any way to take on a role of mental awareness educator. In line with valuing and respecting individual mental health needs, lived experience employees should only perform this educational function if they desire to do so.

Activism

There is no shortage of areas where lived experience employees might experience discrimination. Procknow and Rocco (2016, p. 390) recognise that barriers to equitable salary, training opportunities and career development can consign people with disabilities to "second-class status" in the workplace. Disturbingly, this discrimination can seem natural. To this end, Byrne et al. (2016) notes that a number of participants had become so familiar with biased treatment that they perceived this to be a routine element of their employment experience. Hence, while sanism within Australian workplaces warrants firm policy responses, the normalisation of oppression attempts to squash resistance. Linking back to the topic of epistemic injustice, prejudice against persons with lived experience can even be found within the disability rights movement (DRM) itself. For example, DRM members have conveyed misgivings about people with "invisible disabilities" who pursue participation (Davis, 2005, cited in Wendell, 2013, p. 37). These kinds of dismissive positions ignore the potential of lived experience-led political action against sanism. Conversely, Guidry-Grimes (2017, p. 113) states, "recognition must include removing

the stigma associated with neurodiverse conditions and seeing these individuals as political agents who can form their own culture." While the Plan talks about showing leadership on occasions where discrimination or stigma is witnessed (Commonwealth of Australia, 2017), possibilities for neurodiverse leaders to be politically engaged across the Australian workforce should not be underestimated. However, according to scholarly advice, the general usefulness of activism as a tool against mental stigma has been brought into question. Citing Corrigan and Penn (1999), Williams (2014) cautions that contact and education (rather than protest) were identified as effective anti-stigma measures. Being cognisant of this warning and aligning with the ensuing theme, additional research is also needed to explore how activism, while remaining constructive, targeted and lawful, might also be designed to be more effective in reducing mental stigma.

Research

It is appropriate that research informs social policy in relation to stigma (Williams, 2014). Byrne et al. (2016) suggests that further research into the occurrence of stigma concerning lived experience will deliver added understandings and guidance for future practice. Also endorsed by the literature is exploratory research into the different ways in which employees with mental health conditions deal with discrimination (i.e., sanism) (Procknow & Rocco, 2016). Crucially, the scope of these investigations should be expanded so as to examine the measures that are effective in reducing instances of colonialism-endorsed sanism in the first place. This evidence-based direction is evident in the Plan. Specifically, this national policy includes a measure to "build on existing initiatives, including the evidence base of what works in relation to reducing stigma and discrimination" (Commonwealth of Australia, 2017, p. 40).

In terms of movement toward a broader set of measures with capacity to reduce mental stigma, sanism (or both) within Australian organisations, Figure 1 depicts four incremental levels of research-supported progress. The "level 0 - preliminary set" represents the four measures identified via content analysis of the Plan. Reflecting the study objective to suggest additional themes from the literature that should be addressed in the Plan, the "level 1 - exploratory set" contains all of the level 0 measures plus an additional three measures identified through the Google Scholar enquiry.[2] Moving onto the "level 2 - published set," it is here where future literature reviews utilising wide ranging search terms and databases may reveal a comprehensive list of currently available measures that are suitable for

[2] Each measure is depicted as targeting sanism, mental stigma, or both (as based on the scholarly evidence).

workplace application. Finally, the "level 3 - discovery set" encompasses a dynamic collection (pending funding availability and primary research breakthroughs) of newly constructed treatments. Hence, research conducted at levels 2 and 3 may identify additional themes to those that have been critically discussed within this exploratory study.

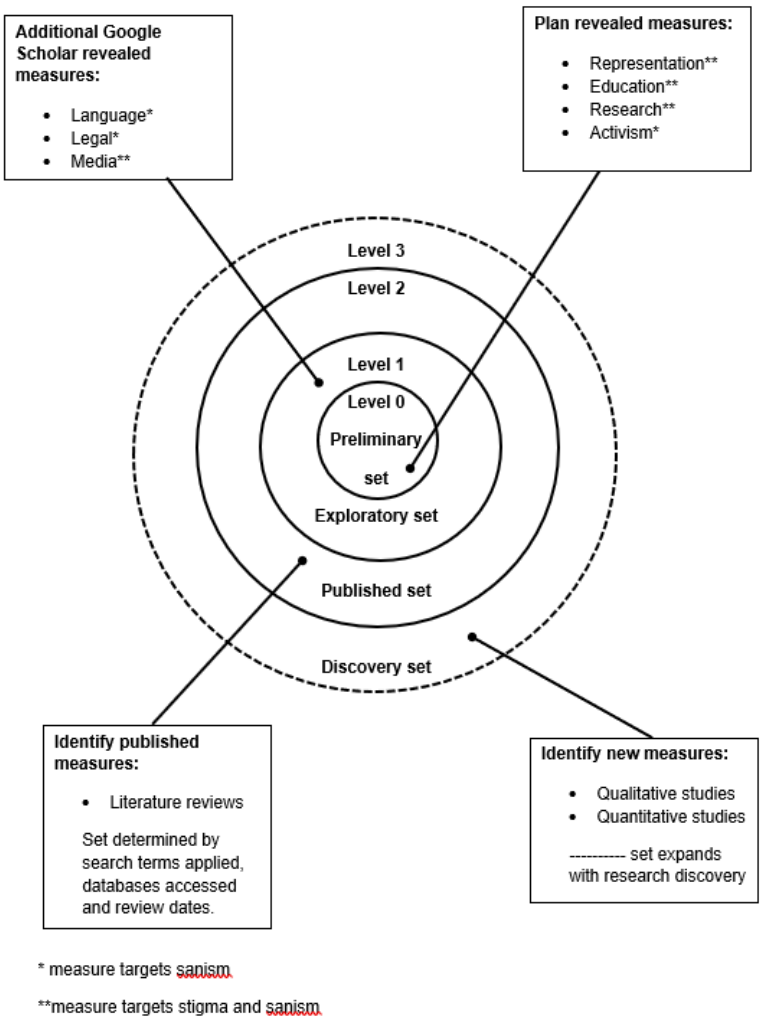

Figure 1. Anti-stigma/sanism levels of research support.

Limitations

Findings of this work are limited to the text results attained from the Google Scholar source and search term applied. Additional studies are therefore needed, which utilise other scholarly sources and expanded search criteria in attempts to identify other measures with capacity to lessen mental stigma and sanism in Australian workplaces and elsewhere. This exploratory research supports the potential of the Plan's measures (along with the three further themes as identified by this study). However, future research is also required to test the effectiveness of these measures when applied either individually or within various suite configurations across different organisational settings.

Conclusion

This exploratory research reveals three primary messages that policymakers who are responsible for promoting mental health through greater levels of social and economic inclusion should find engaging. First, the workplace mental stigma and sanism reduction measures as identified within the Fifth National Mental Health & Suicide Prevention Plan are limited in the sense that they represent only a subset of those currently available. This investigative study recognises additional themes of media, language and legal. Further research activity in the form of literature reviews and discovery projects are needed to maximise the identification of evidence-based strategies to advance more inclusive workplaces. Second, potential exists for measures to operate collaboratively. Possible connections among particular themes suggest a need for careful thought and planning to be given to national mental health policy coordination activities. Finally, potential exists for anti-mental stigma and discrimination actions that specifically target the health and peer workforce to be implemented more broadly throughout Australian workplaces. It is appropriate for national mental health policy to enthusiastically examine this potential in efforts to reduce lived experiences of social and economic exclusion.

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