

## Discrimination and Positive Treatment Toward People With Mental Health Problems in Workplace and Education Settings: Findings From an Australian National Survey

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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 5,220 Australians aged 18+, 1,381 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, whereas 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, and 10.8% focused on anticipated discrimination and mentioned not disclosing their mental health problems during the recruitment process for fear that doing so would have resulted in a negative reaction from prospective employers. The results can provide input into the design of antidiscrimination 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.

**Keywords:** mental disorders, discrimination, stigma, positive treatment

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 marginalization (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

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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 toward work and education, the service system, financial disincentives to work and stigmatizing attitudes and discrimination (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; McDowell & Fossey, 2015; Rutman, 1994; Thornicroft, Brohan, Rose, Sartorius, Leese, & The INDIGO Study Group, 2009). Studies of employers' attitudes toward 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 counseling services and disability liaison units. Although assessment of stigmatizing 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.

## Method

The survey involved computer-assisted telephone interviews (CATI) with a national sample of 5,220 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 dialing of both landlines and mobile phones. This approach was taken in order to minimize the potential bias of collecting data solely from households with a landline telephone connection, as the latter approach may undersample 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 min. 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, posttraumatic stress disorder/PTSD, agoraphobia, panic disorder, obsessive-compulsive disorder/OCD, social phobia, generalized 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: (a) 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 (b) 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 neighborhood and other people and other situations. The data on these latter questions are reported elsewhere (Reavley & Jorm, 2015).

### Statistical Analysis

The data were analyzed 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 underrepresentation of males and of younger adults, and an overrepresentation 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).

### 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 analyzed by one of the authors (AJM) to develop a draft coding system with instructions, examples and counterexamples. 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 behavior. Once the coding framework was finalized, 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, 5,220 interviews were completed, with 2,589 on landlines and 2,631 on mobiles. The standard response rate for the survey was 37.5%. Of the respondents, 1,381 (28.8%) 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 1,159 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). In terms of employment status, 992 (72.1%) of respondents 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, 2,703 (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 1,568 (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, 1,271 (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, 1,626 (61.6%) respondents re-



Table 1  
*Clinical and Sociodemographic Characteristics of  
 Respondents Classified as Having a Mental  
 Health Problem*

Characteristic	Weighted %
Mental health problem <sup>a</sup>	
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

Note. PTSD = posttraumatic stress disorder; OCD = obsessive-compulsive disorder.

<sup>a</sup> Multiple diagnoses were possible.

ported that the person had told them, 1,363 (50.1%) reported that they recognized it and 644 (23.8%) reported that someone else told them. Of these, 1,665 (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.** A total of 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 behavior 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 do not believe in it (male, age range = 20–24, depression and anxiety disorder).

**Forced to change responsibilities or denied opportunities.** Of the respondents, 29 (24.4%) 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 cannot 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).

Table 2  
*Experiences of Discrimination and Positive Treatment by People in the Workplace or Place of Education Over Previous 12 Months*

Experiences of avoidance, discrimination or positive treatment	Experiences reported by people w/MHP % [95% CI]	Experiences reported by people who knew another adult w/MHP % [95% CI]
People in the workplace	(n = 992)	(n = 1,665)
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]

Note. MHP = mental health problem; CI = confidence interval.

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.** A total of 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.** A total of 15 (12.6%) respondents reported being judged negatively, criticized, treated differently or treated as incompetent because of behavior related to their mental health problem.

My previous employer just continually criticized 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.** Of the respondents, 8 (6.7%) 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, for example, 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 was not able to get it because it was not 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

**Nonspecific support or help.** A total of 126 (54.3%) respondents mentioned getting support or more support than usual.

I think my bosses appreciated the situation 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.** A total of 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.** A total of 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.** A total of 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 your 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.** A total of 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 counseling 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.** A total of 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 range = 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 will not get the job (male, age range = 50–54, depression).

**Anticipated discrimination.** A total of 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

**Nonspecific support.** A total of 7 (33.3%) respondents reported that people were positive, understanding or supportive toward them.

The new employer (I told them these issues) and they understood and empathized 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 backward, they'll save you (female, age range = 40–44, anxiety disorder).

**Job-seeking support.** A total of 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.** A total of 8 (34.8%) respondents reported a lack of understanding about how mental health problems can affect behavior and performance, or how to deal with them.

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 do not listen to my problems and I do not learn and I stress more. Teachers definitely need a little help (female, age range = 18–19, no diagnosis).

**No leniency or special consideration.** A total of 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.** A total of 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.** A total of 64 (70.3%) respondents specifically mentioned being given special consideration or extra time to complete assignments, extra help or other adjustments.

**Nonspecific support.** Of the respondents, 23 (25.3%) 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.** A total of 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 counselors at TAFE. It helped me to keep going with the course, it was free and really good. It was really helpful (fe-



male, 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 article 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, whereas 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, and 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 underreported compared with 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 stigmatizing 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 antistigma 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 be-

ing shown a lack of understanding about how mental health problems affect behavior 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 beyond-blue's Heads Up program in Australia (<https://www.headsup.org.au/>), Time to Change in the U.K. (Henderson, Williams, Little, & Thornicroft, 2013) and Opening Minds in Canada (Mental Health Commission of Canada, 2013). A recent review of workplace antistigma interventions found that effects on knowledge, attitudes and behaviors 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. Although 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 reported in the current study 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, and 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 toward underreporting 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 toward overreporting 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, although in line with other similar Australian surveys, may limit the generalizability 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 antidiscrimination 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.


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