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Peer Work and Stigma Reduction in Australian Mental Health Policy: Tackling Sanism or Reinforcing the Status Quo?

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ABSTRACT *Peer workers are increasingly included as part of mental health policy approaches to stigma, reflecting ongoing imperatives to include lived experience within mental health policy and practice. Using a post-structural analysis of Australian mental health policy, we critically examine the effects of such inclusion on dominant enactments of peer work and stigma. We find that mental health policy predominantly produces stigma as a problem of individual lack of capacity and responsibility, reinforcing neoliberal and psychiatric logic that locate individuals as the site for intervention and mental health practitioners as the experts to undertake such interventions. The inclusion of peer workers, predominantly enacted as role models, promotes the appearance of progressive governance whilst distracting from the socio-material conditions and processes that mark individuals as other, and leads to significant harm when individuals seek support. Dominant enactments of stigma thus remain undisturbed by the inclusion of peer work within mental health policy. Our findings challenge the notion of inclusion of lived experience via the peer workforce as universally progressive, calling for a more nuanced examination of the effects of inclusion. We propose sanism as an alternative problematisation that aligns more closely with peer work and social justice. We conclude with practice and research recommendations.*

KEYWORDS sanism; stigma; Mad Studies; mental health policy

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Introduction

Mental health policy approaches to stigma increasingly include peer workers, as individuals with lived experience of stigma, as part of the solution to stigma reduction. Such moves reflect ongoing imperatives to include lived experience within mental health policy and practice (Fey & Mills, 2021; Voronka & Costa, 2019), and the recognition that individuals have a right to inform policies that concern them (Thornicroft et al., 2022). In this article, we examine the potential effects of this inclusion imperative, using a Bacchian post-structural analysis (Bacchi & Goodwin, 2016) of Australian mental health policy to examine how stigma and peer work are enacted in policy. That is, rather than ask "what works?" in relation to stigma reduction, we take a step back and ask "what is the *problem* represented to be that peer workers are solving?"

Such considerations are important as whilst the existence of stigma is largely undisputed, conceptualisations of both stigma and peer work, and thus the problem that needs resolving, are highly contested (Sinclair et al., 2023; Tyler & Slater, 2018). Despite seeming self-evident, conceptualisations of stigma and peer work, like all concepts, are enacted through a range of socio-material forces, including research, policy and activism, with such enactments having material effects on people's lives, shaping what is possible to think, feel and do (Bacchi & Goodwin, 2016; Tyler & Slater, 2018). The inclusion of peer work within mainstream mental health policy and practice holds potential to produce peer work and stigma in ways that sit in tension with consumer/survivor desires for social justice and humane responses to distress, reinforcing the subordination of people experiencing distress or seeking support (Adams, 2020; Costa et al., 2012; Fabris, 2013; Mahboub, 2019; Rebeiro Gruhl et al., 2016; Sinclair et al., 2023, 2024; Stratford et al., 2019; Voronka & Costa, 2019). As such, there is a need to critically examine how stigma is enacted in particular ways, the premises that such enactments rest upon, and the subsequent effects for peer work and others entangled with mental health services.

Like many countries, Australia's approach to stigma has changed little since the introduction of the first national mental health policy in 1992. Anti-stigma and mental illness awareness campaigns continue to be funded (Fey & Mills, 2021), with little structural change to mental health laws (Maylea, 2023) nor the introduction of vilification laws (Katterl, 2023). However, a recent change, present within Australia's Fifth National Mental Health and Suicide Prevention Plan ("the National plan"), involves the inclusion of peer workers as "effectively tackling stigma and discrimination" (Commonwealth of Australia, 2017, p. 39). As part of the National Plan, Australia's National Mental Health Commission has been tasked with developing a National Stigma and Discrimination Reduction Strategy. This is yet to be released after being provided to the Commonwealth Government (Carmody, 2024), however recommendations informing the strategy include utilising lived experience and strengthening peer work as an emerging discipline (Centre for Mental Health,

2021). Given that the inclusion of peer workers provides potential for a change in how stigma is conceptualised and responded to, there is an urgent and critical need to examine whether this is supported through policy, or whether peer workers simply become an add on to existing solutions through inclusion, as has occurred elsewhere (Sinclair et al., 2023, 2024; Voronka & Costa, 2019).

Analysing policy using Bacchi's (Bacchi & Goodwin, 2016) "what's the problem represented to be" (WPR) approach is one way to reveal how peer workers are enacted in relation to stigma, and the potentially problematic effects of such enactments. WPR has been well utilized in examining policy approaches to alcohol and other drug use (Lancaster et al., 2017a, 2017b; Madden et al., 2021; Martin & Aston, 2014; Pienaar et al., 2018), and is increasingly recognized as useful for examining mental health policy (Cohen et al., 2024; Cui et al., 2019; O'Connor et al., 2023; Rawson et al., 2024; Sinclair et al., 2024). Rather than assuming a pre-existing problematic situation exists outside of policy processes, the approach involves analysing how "problems" are *produced* (given shape and meaning) within policies (Bacchi, 2016). That is, rather than conceptualising policy as addressing a pre-existing "problem" of stigma, WPR prompts an analysis of what, and how, certain situations, objects, or subjects, like stigma, are made into particular kinds of "problems" through policy, and thus responded to in particular ways.[1]

In critically examining the effects of peer work inclusion in stigma reduction, we remain steadfast in upholding the right (and value) of individuals most affected by stigma to define the nature of the problem, and accordingly, how it should be responded to. Through our analysis, we question whether the inclusion of peer work in dominant conceptualisations of stigma moves practices closer to eradicating the exclusion, discrimination, and human rights violations perpetuated against individuals who experience life-unsettling distress or access (or are forced to access) mental health services. Asking "what is the *problem* represented to be that peer workers are solving?" enables a consideration of whether current problematisations that peer workers are entangled with moves us closer to such goals, or whether alternative problematisations are worth pursuing.

Methodology

A WPR analysis is guided by a set of questions that can be employed systemically or as part of an integrated analysis, with specific questions applied depending on the analytical focus (Bacchi & Goodwin, 2016). For this article we present analysis related to questions one, four and five, focusing on the entanglement of peer work and stigma. Question one asks "what is the problem

[1] Following Bacchi and Goodwin (2016), we occasionally use scare quotes for the term "problem" and "mental illness" to signal that we are unsettling such concepts as fixed and readily identifiable entities.

represented to be in policy?" To answer this question, a WPR analysis starts with considering the proposed solution, given that what one proposes to do about something indicates what one thinks needs to change, and hence what is produced as problematic (Bacchi, 2016). We thus start with outlining the proposed solution and therefore the dominant problematisation in policy (question 1) and its subjective effects (question 5), looking specifically at how stigma problematisations produce a particular *kind* of peer work. Lastly, we consider how the "problem" might be conceived differently (question 4).

Our analysis takes as its focal point Australia's Fifth National Mental Health and Suicide Prevention Plan ("the National Plan"). The National Plan is the highest-level Commonwealth government-endorsed document including peer work as part of a policy response to stigma. The Plan identifies eight priority areas (problematic situations), with stigma and discrimination one of only two priority areas that involve peer workers as part of a solution. Texts associated with the policy were drawn on to develop a fuller understanding of the background to the issue and the wider debates (Bacchi, 2009), including state policy responses, frameworks and government funded anti-stigma campaigns that reference peer workers.

To evaluate the potential effects of problematisations for peer work, we have drawn on ideas from within Mad Studies, critical mental health studies and consumer/survivor activism. This work sensitises our analysis to issues of epistemic injustice, psy-related harms, and alternative problematisations put forward by those with lived experience of stigma within mental health systems (Beresford & Russo, 2021; Costa & Ross, 2022; LeFrançois et al., 2013; Russo & Sweeney, 2016). The analysis was predominantly undertaken by the first author, but was deepened through discussion and contributions from all authors, drawing on our differences in academic backgrounds, lived experiences and positionings to facilitate "uncomfortable reflexivity" (Pillow, 2003, p. 175).

Analysis

Peer Workers as a Solution to Stigma

In relation to stigma, the National Plan proposes "a sustained and collective effort to dispel the myths associated with mental illness" (Commonwealth of Australia, 2017, p. 39). This solution, involving shifting public attitudes to mental illness through education, has a long history in both Australian mental health policy, and internationally (Fey & Mills, 2021; Speed & Taggart, 2019; Tyler & Slater, 2018). Australia's First National Mental Health Plan, for example, initiated a community awareness mass media campaign and studies of community and staff attitudes to "people with mental illness," whilst the second included a "Mind Matters" program of school mental health education (Rosen, 2006). Little has thus changed regarding proposed stigma solutions

between Australia's first mental health policies, over 30 years ago, and the current national policy. This approach has seen large amounts of government funding allocated to high-profile marketing and public awareness campaigns that promote mental illness as similar to a physical illness; an illness that can affect anyone, should be talked about, and can be recovered from (Tseris, 2019).

Within the Plan, people with a lived experience, notably peer workers, are proposed as "a central part of effectively tackling stigma and discrimination" through involvement in such educational strategies (Commonwealth of Australia, 2017, p. 39). Peer workers, for example, are produced as "well placed to assist in progressing… interventions" (p. 40) such as Mental Health First Aid (MHFA), a two-day training course that aims to increase mental health literacy, teaches people to identify individuals who may have "mental health problems," assess the risk, and encourage professional help seeking (Commonwealth of Australia, 2017, p. 40). MHFA sits alongside many other anti-stigma campaigns that aim to educate the general community, utilizing principles of both education and social contact theory. Peer workers are produced as positive role models within such approaches, "presenting a more humane face of the mentally ill" and showing that recovery, via mental health treatment, is possible (Speed & Taggart, 2019, p. 7). SANE Australia, for example, whose current tagline is "we're people like you," uses "peer ambassadors" to share "unfiltered real-life stories" to "raise awareness, reduce stigma and provide hope" (SANE Australia, n.d., para. 1). This inclusion of lived experience in "interventions that use social contact" again reflects international trends (Thornicroft et al., 2022, p. 1438).

In addition to demonstrating "we're people like you" to the general public (SANE Australia, n.d.), peer workers are enacted through the Plan as "effective role models" for individuals who are deemed in need of mental health services (Commonwealth of Australia, 2017, p. 39). Such role modelling involves "improv[ing] a person's capacity to respond to stigma and discrimination" (p. 39): encouraging help seeking behaviour by "promot[ing] the use of mental health services" (p. 25) and supporting adherence to treatment by "modelling positive outcomes from service experiences" (p. 46).

The "Problem" that Peer Workers Address within Policy

These solutions to the problem of stigma contain representations of the causes of the problem (Bacchi & Goodwin, 2016). From the solution of education, for example, the problem of stigma, as reflected and produced through the National Plan, might be understood as one of ignorance, caused by a lack of knowledge. That is, it is assumed that better understandings of mental illness will lead to "improved attitudes towards people with mental illness" (Commonwealth of Australia, 2017, p. 12). The problem of stigma is thus enacted as existing within the mind of the individual holding the stigmatizing

view, with the solution involving correcting this lack of knowledge through education. Stigma is thus enacted through policy as an individual level cognitive labelling process, drawing on Goffman's (1963) theorising of stigma as a response to a negatively-viewed attribute (Holley et al., 2012).

However, our analysis suggests lack of knowledge is only part of the problem represented. The solution of peer workers role-modelling recovery via mental health treatment suggests stigma is a problem *because* it prevents individuals from "disclosing" they have a "mental health problem," and thus seeking help (Commonwealth of Australia, 2017, p. 40). What is problematised then, is not so much the lack of public knowledge, but rather the lack of help seeking behaviour; the individual who is yet to disclose "*their* disorder" (Commonwealth of Australia, 2017, p. 6, emphasis added), seek treatment, or adhere to treatment. More specifically, the problem is produced as a lack of individual capacity to respond to the distress created by stigma in ways considered appropriate. Stigma itself is not conceptualized as preventing people from accessing help, nor a multitude of other potential reasons, including inaccessible, ineffective, or harmful mental health services. Rather, it is a *lack* of individual capacity, skill or responsibility to overcome the feelings of "shame, helplessness, fear, worthlessness and self-doubt" associated with stigma (Commonwealth of Australia, 2017, p. 39).

This problematisation is prevalent in many anti-stigma campaigns, both in Australia and internationally, that encourage individuals (or enlist families and supporters to encourage individuals) to access mental health services to enable recovery (see e.g., Grey, 2016, p. 244; Tyler & Slater, 2018). Addressing such barriers requires overcoming the shame and attitudes associated with labels of mental illness. In this respect, the aim of many stigma campaigns could be summarized as to "eradicate stigma so that people are willing and able to access services" (Tyler & Slater, 2018, p. 726). This problematisation of stigma, as an individual's (in)ability to rise above or overcome stigma, is also reflective of broader problematisations of individuals targeted within Australian mental health policies, where the individual is situated as the site of the problem, and thus site of intervention (Cui et al., 2019; Henderson & Fuller, 2011; O'Connor et al., 2023; Peterie et al., 2024).

Underpinning this problematisation lies assumptions that certain types of distress exist as objective entities; "mental illnesses" that can (and should) be objectively recognised, classified, and acted upon, presupposing narrow bio or psychological solutions to the problem (Fey & Mills, 2021; Longdon & Read, 2017; Sayce, 2016; Thachuk, 2011; Tyler & Slater, 2018). It is assumed that diagnosis and treatment resolves stigma. That is, that once intervention occurs at the point of illness, through treatment and reduction in abnormal symptoms, there will be a reduction in stigma. Stigma is attached to mental illness as the marker of difference, and thus if the mental illness is resolved, so to the stigma.

The genealogy, assumptions, and limiting effects of this problematisation have been examined, evaluated, and critiqued extensively elsewhere (Corrigan et al., 2017; Cui et al., 2019; de Bie, 2022; DeFehr, 2016; Fey & Mills, 2021;

Henderson & Fuller, 2011; O'Connor et al., 2023; Sapouna, 2020; Thachuk, 2011; Tseris, 2019). Such approaches to stigma reduction have been criticized for benevolent othering (Grey, 2016), biological reductionism (Anonymous Female, 2019; Thachuk, 2011), colonialism (Fey & Mills, 2021) and, in relying on individual enactments of stigma, failing to address the sociopolitical functions that stigma serves and for whom (Holley et al., 2012; Tyler & Slater, 2018). Rather than reiterate such critiques, we turn our focus to how peer workers are predominantly enacted through such a problematisation, and the potential effects of such enactments.

What do Peer Workers Become Within such a Problematisation?

Our analysis revealed that through inclusion in mental health policy approaches to stigma, peer workers become subjects that deliver interventions at an individual level. More specifically, peer workers become subjects that work therapeutically with stigmatized individuals to orientate them towards help seeking, and once diagnosed orientate them towards compliance with mental health treatments. Peer work thus becomes narrowly limited to an enactment of peer support that involves orientating individuals towards feelings and behaviors that cooperate with psy-regimes of governance (Sinclair et al., 2023; Voronka, 2017). Tyler & Slater (2018) refer to such as schooling the stigmatised to better manage their stigmatised difference" (p. 729). Whilst peer workers are included in community education, they become educators of "mental illness", with the end goal of bringing more people into mental health services, asserting that mental health treatment, and mental health professionals are the only people capable of providing support.

A common subjective effect of problematisations is the production of a polarising dynamic between groups of people, with such dividing practices having implications for how governing occurs by drawing normative distinctions between groups (Bacchi & Goodwin, 2016). This occurs through the dominant problematisation present in stigma reduction policies; peer workers become good, responsible mental health services users who have overcome stigma to actively engage in recovery, divided from the problem group; those that need "help" to "take responsibility," seek help or adhere to treatment. That is, peer workers are positioned as separate from, and better than, individuals they are expected to support.

Ironically, whilst peer workers are enacted as responsible for tackling the problem of stigma from a position of being a recovered service user, peer workers commonly identify stigma and discrimination, both towards themselves, and other consumers and carers accessing services, as one of the major issues they face in the workplace (Byrne et al., 2019; Edan et al., 2021; Seal et al., 2024). Such experiences suggest being positioned as a recovered service user does not eliminate stigma or discrimination. Whilst the concept of mental illness remains firmly entrenched as existing inside certain bodies and

minds, the subject of peer worker becomes the embodiment of difference, reifying the idea of "those" people, who are both different from the general public and the general mental health workforce. Peer workers, to quote SANE Australia (n.d) become "people like you"; responsible citizens but still other to the public and mental health workforce.

Such enactments of peer work, as role models delivering interventions to individuals to overcome the stigma of having a disorder, sit in tension with enactments of peer work produced through consumer/survivor movements, as an emancipatory practice grounded in a human and civil rights perspective and underpinned by mutuality. A criticism of both contemporary anti-stigma policy and research has been its failure to engage with such movements (Faulkner, 2017; Fey & Mills, 2021; Katterl, 2022). In its contemporary form, peer work developed within the consumer/survivor movement in response to an exclusionary and harmful psy-practices, both within mental health systems and society more broadly. Consumer/survivor enactments of peer work uphold the rights of social inclusion for all individuals to participate as full citizens regardless of so-called treatment or cure (Davidson & Roe, 2007; Sayce, 2016; Stratford et al., 2019), advocating for both system and societal transformation as well as care and supports for individuals experiencing distress without coercion or pathologisation (Stratford et al., 2019).

Conceptualising the Problem Differently

An alternative problematisation of mental health stigma comes from the concept of *sanism* (Chamberlin, 2005; Fabris, 2011; Holley et al., 2012; LeBlanc & Kinsella, 2016; Perlin, 2013; Poole et al., 2012; Sinclair, 2018; Wolframe, 2013). Sanism is conceptualised as "the systematic subjugation and oppression of people who have received 'mental health' diagnoses, or who are otherwise perceived to be 'mentally ill'" (LeBlanc & Kinsella, 2016, p. 62). LeBlanc and Kinsella (2016) contend that sanism is "arguably one of the last socially accepted, government-sanctioned forms of systemic discrimination against a large social group" (p. 63).

By conceptualising stigma as sanism, the social, institutional and structural aspects of stigma are brought to the fore. Stigma becomes a human rights issue. It draws attention, for example, to how mental health laws, as laws that strip away the rights of people experiencing distress to subject them to forced treatment and incarceration, remain unmentioned in stigma reduction policies. It draws attention to the "gross human rights violations" (Katterl et al., 2023, p. 6) within mental health systems, such as the use of force (Maylea & Hirsch, 2017), which have been linked to systems built "on a bedrock of fear and stigma" (Katterl et al., 2023, p. 6). It highlights how individuals continue to experience discrimination in housing, relationships, access to government assistance, and healthcare (Sayce, 2016; Speed & Taggart, 2019; Thachuk, 2011) with limited legal redress (Katterl, 2023). Systems – rather than

individuals – are thus problematised as perpetrators of sanism.

As opposed to dominant enactments of stigma that see diagnosis and treatment as part of the solution to stigma, an enactment of stigma as sanism conceptualises diagnosis and treatment as part of the problem of stigma. Research suggests, for example, that biogenetic explanations of distress reify ideas of individuals experiencing distress or labelled as mentally ill as other, amplifying a desire for social distance (Holley et al., 2012; Longdon & Read, 2017; Sayce, 2016; Thachuk, 2011). Designating individuals as other enables differential (often discriminatory or violent) treatment; it makes it possible for individuals to "be taken against their will to the hospital; for workers to be denied employment because of 'mental health' histories; or, for Mad students to be excluded from social work programs" (Poole et al., 2012, p. 23)

Stigma as sanism also highlights how such discriminatory practices are tightly entangled with sexism, heterosexism, racism, classism and other identity-based oppressions (Meerai et al., 2016; Poole et al., 2012). In Australia, for example, sanism is closely entangled with the colonisation of First Nation peoples. Historical and ongoing colonial systems and practices contribute to significant distress for Aboriginal and Torres Strait Islander people (Dudgeon et al., 2014; Lee et al., 2024; Tatz, 2005; Thurber et al., 2022), whilst psychiatric diagnostic practices and mental health systems continue to discriminate across racial lines and subjugate the critical theorising, knowledges and healing practices of First Nation communities (King, 2016; Tatz, 2005). Sanism as a conceptual framework problematises the silencing of the ongoing effects of colonisation as highlighted by critical Indigenous scholarship, within mainstream enactments of both stigma and peer work. Stigma as enacted in mental health policy works in tandem with the ways in which Aboriginal and Torres Strait Islander peoples are enacted as dysfunctional and "domesticated" within a framing of "domestic welfare policy – rather than legal agreements – as the 'solution' to settler colonial conflict" (Strakosch, 2019, p. 114).

Regarding peer work, the conceptualisation of stigma as sanism disrupts the epistemic injustice involved with an enactment of peer workers as an add-on to existing stigma solutions. Rather, peer workers may be considered as alternative knowledge holders, bringing together lived experience with survivor and Mad theorising to enact alternative problems and thus solutions, such as challenging the psychiatric establishments role in perpetuating exclusion, and how community supports, that don't rely on treatments to "fix" individuals can promote a sense of belonging and citizenship (Cogan et al., 2021).

Conclusion

Through a WPR analysis of Australia's national mental health policy, we have shown that, through inclusion within solutions to stigma, peer work becomes

entangled with practices of social and moral regulation of individuals deemed to be, or at risk of becoming, "mentally ill." The inclusion of peer work in mental health policy reifies the problem of stigma to be one of untreated mental illness and a lack of individual responsibility and capacity to seek out biomedical or psychological treatment. Ironically, through inclusion in mental health policy, peer workers become implicated in exclusion, despite measures that seem on the surface to be socially progressive. Faulkner (2017) in critiquing anti-stigma interventions, has argued that until structures, laws and practices are altered, "all we have is warm sentiments" (p. 779). Through inclusion, peer work becomes part of these warm sentiments.

Whilst our analysis focuses on Australian mental health policy, dominant approaches to stigma reduction in Australia reflect international trends, and thus we suspect similar effects may be occurring internationally. Our findings also have broader implications for the inclusion of lived experience within mainstream mental health policy and practice. As highlighted by others, the inclusion of lived experience into systems does not automatically equate to changes in dominant problematisations. Individuals with lived experience of stigma are not a homogenous group, nor are our perspectives and practices formed within a socio-politico-historical vacuum (Daya et al., 2020; Tseris et al., 2022). As such the inclusion of lived experience does not necessarily equate to the inclusion of a range of knowledges and practices grounded in lived experience, particularly those that align with consumer/survivor, Mad and social justice movements more broadly. Careful and ongoing consideration needs to be given to the way in which inclusion is enacted through peer work, both within Australia and internationally, and whether inclusion redefines or simply reifies dominant problematisations.

Recommendations

Based on our analysis, we recommend a shift in research, policy and practice from stigma to sanism, bringing us closer to reducing the violence perpetrated within mental health systems and society more broadly. This may include the following:

- A focus in advocacy on changes to mental health laws (Maylea, 2023) and the introduction of vilification laws (Katterl, 2023);
- Further investigation into where and how alternative problematisations of stigma are already enacted, such as stigma as sanism. This may include investigation into the conditions that enable peer workers within mental health systems to conceptualise and respond to sanism, such as spaces and resources that enable peer workers to collectively engage with critical mental health theorising and Mad Studies;
- Closer attention to the ways in which sanism is intertwined with other practices of discrimination perpetuated within psychiatric systems and

practices, centring the lived experiences of those most affected by such violence;
- A shift from assuming the inclusion of peer workers as a universally beneficial move, to thinking critically about the effects of inclusion for those most harmed by psychiatric systems and practices.

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