

2001



LIKE MINDS, LIKE MINE
Whakaitia te Whakawhiu i te Tangata

National Plan 2001–2003

Project to Counter Stigma and
Discrimination Associated with
Mental Illness

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Foreword

Last month I attended the World Health Assembly in Geneva. The theme for the Assembly was mental health, and it was pleasing to see the high level of interest that New Zealand's "Like Minds, Like Mine" project received. A number of the 190 different countries attending the forum were impressed with the project resources that we took with us. WHO Director-General Bruntland showed a special interest, and also took home a copy of the Sticks and Stones documentary, the TV ads and a draft of this National Plan.



Reducing stigma and discrimination associated with mental illness, and developing and retaining the mental health workforce, are two of the most important areas for the mental health sector. Empowering people with experience of mental illness, and educating others about what mental illness is, are also key aims of this National Plan.

In order to implement the Plan over the next two years, we will have to keep breaking new ground, and it is essential that all key groups continue to work and communicate effectively together. The work already done by individuals and groups has established a good level of community awareness that will support the range of activities in the Plan.

Changing attitudes and behaviour is very challenging, but I know that with the commitment of all those involved in the project we will move steadily towards creating a nation that values and includes people with mental illness.

A handwritten signature in black ink that reads "Annette King". The signature is written in a cursive, flowing style.

Hon Annette King
Minister of Health

Preface

I will never forget the first time I entered a psychiatric hospital. It was one of the most abrupt and unwelcome transitions of my life. In one afternoon I stopped being a privileged young citizen and became a psychiatric inpatient – stripped of my clothing, my credibility and my dreams. As I emerged from my devastating existential crisis I had to tell myself that I was now ‘one of them’. One of the loonies we used to joke about as kids. One of the crazy people we used to avoid in the street. One of the mental patients whose mental illness we thought had destroyed their humanity.



Looking back, the experience of joining a group I discriminated against was one of the most valuable lessons of my life.

Since the day I first went into hospital I have known from the core of my being that the discrimination and social exclusion of people with mental illness is unarguably wrong. Yet discrimination against people with mental illness pervades our history, our mental health system and just about every institution, household and ethnic group in this country.

The Mental Health Commission in its *Map of the Journeys towards Equality, Rights and Respect for People with Experience of Mental Illness* talks about ‘zero tolerance of discrimination’. That is the only ethical position a good and informed human being can take. That is the position the ‘Like Minds, Like Mine’ project must insist upon.

The National Plan for 2001–2003 shows a good understanding of the complexity of the ‘Like Minds, Like Mine’ project while remaining clear about its purpose and the people who must benefit from it. It draws on the lessons of the first few years of the project and makes a well-informed attempt to chart the way forward. All that is needed now is everyone’s commitment, co-operation and ingenuity to implement it.

Mary O’Hagan
Mental Health Commissioner

Acknowledgements

This National Plan has built on the work and contributions of many people over the last five years. It is not possible to name them all, but special thanks need to go to Janet Peters, Monica Briggs and Warren Lindberg, who have been national project managers for this project at different stages. We would also like to thank all the contracted providers, individuals, organisations and especially the project's National Advisory Group, whose work, insights and views have been essential to the successful development of the project and this National Plan.

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Introduction

'We support a public awareness campaign – it is a must. It is fundamentally wrong that a vulnerable group in our society should be continually subjected to the comments and actions of those who possess an outcast mentality ... We are optimistic enough to believe that a well-informed New Zealand public will then realise that [people with a mental illness] are people whom we should nurture and value.' (Mason Report 1996)

The Project to Counter Stigma and Discrimination Associated with Mental Illness was established in response to a recommendation of the 1996 Mason Report (Inquiry under section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services) as a five-year project due to end in 2001. The Government has now extended the Project as a component of public health baseline funding. This document updates the National Plan for the Project which was published in May 1999 and outlines the direction of the Project for the three years from July 2001 to June 2003.

The 'Like Minds, Like Mine' logo

The logo was developed from the winning design submitted through a consumer art competition held in 1998. The philosophy behind the mathematical symbol used in the design is 'greater than discrimination, equal to others'.

The slogans

Generally, the slogan 'Like Minds, Like Mine' is a play on the phrase 'we are all of like mind'. In essence, it means we are all the same in that mental illness can happen to you, me or anyone.

The Māori slogan 'whakaitia te whakawhiu i te tangata' is not a translation of the English slogan. This slogan, agreed on at the 1998 National Māori Stakeholder Hui, is translated as 'reduce your potential to discriminate'.

Consultation

Revision of the National Plan commenced in February 2000 with a review of the advice contained in the process evaluation reports available at that time (Appendix 1). The key issues that were identified in the reports were discussed in a series of forums with the National Advisory Group, the Health Funding Authority's Mental Health Promotion Workstream, Project providers, and other significant stakeholders such as the Mental Health Commission. Draft changes to the strategic objectives and work plan were endorsed at the National Provider Seminar in November 2000.

Vision, Aims and Principles

The vision, aims and guiding principles stated in the 1999 plan remain unchanged. However, some changes have been made to clarify the strategic objectives, and an objective specifically addressing the role of Māori and Pacific peoples in the Project has been added. The term ‘consumers/tangata whaiora’ has been replaced by ‘people who have experience of mental illness’.¹

Vision

Working towards creating a nation that values and includes people with mental illness.

Aims

To reduce the stigma associated with mental illness and reduce the discrimination experienced by people with mental illness by:

- empowering individual people with experience of mental illness to gain equality, respect and rights
- putting mental health on people’s personal agendas
- educating people about what mental illness is
- promoting greater understanding of, acceptance of, and support for people with mental illness
- changing public and private sector policy to reflect the above
- communicating the above effectively with all key groups in New Zealand, including people with experience of mental illness, statutory agencies, GPs, health agencies, other governmental agencies such as Housing New Zealand, and people with other disabilities.

¹ In the 1999 National Plan the term ‘consumers/tangata whaiora’ was used. The National Advisory Group has requested that the Project now adopt the phrase ‘people who have experience of mental illness’ as the preferred term. The term ‘tangata whaiora’ is also used.

The guiding principles

The work of the Project will be guided by the following nine principles:

1. Acknowledge and build on the good work already done by individuals and groups in this area.
2. Ensure the Project activities are driven by the focus of reducing stigma and discrimination for people who experience serious mental illness and where possible that people with experience of mental illness will be employed and remunerated for their skill and contribution.
3. Ensure Māori perceptions and experiences of stigma and discrimination are acknowledged and valued throughout the Project. This requires Māori participation at all levels in accordance with the Treaty of Waitangi.
4. Ensure Pacific peoples' perceptions and experiences of stigma and discrimination are acknowledged, included and valued throughout the Project.
5. Ensure that people who are actively working within the Project model the attitudes and behaviours that we wish to encourage in others. In other words, that we practise what we preach in valuing others.
6. Ensure families/whānau are involved and their contribution is valued.
7. Collaborate with the Mental Health Commission's anti-discrimination work.
8. Ensure that local programmes are consistent with the National Plan.
9. Ensure that national activities support and enhance local activities.

Critical Success Factors

Evidence from other efforts to change social attitudes and behaviour suggest the following factors are critical to the success of the Project:

A comprehensive health promotion approach

Mental Health Commissioner Barbara Disley pointed out in 1997 that the developing body of knowledge about health promotion was only beginning to be applied to mental health (Disley 1997). The basis of health promotion is its comprehensive approach, addressing the five areas for action identified in the *Ottawa Charter for Health Promotion* (World Health Organization 1986): building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and re-orienting health services.

This approach is supported by Barwick's (1995) review of the literature on changing public attitudes towards people with mental illness, which identified the following key influences in order of effectiveness:

- direct contact with people with mental illness
- indirect exposure via the media to people with mental illness
- information and persuasion.

Active involvement of people with experience of mental illness

Studies of attitudes towards people with mental illness consistently find that people who know someone with a mental illness are less likely to hold negative stereotypes and are less likely to perceive people with mental illness as dangerous. These findings lead researchers to conclude that negative attitudes can be reduced by promoting direct contact between members of the public and people with experience of mental illness. For this reason, involvement of people with mental illness is essential. Donaldson (1980) found that structured experiences or presentations involving people with mental illness were more effective than informal contact, mainly because structured situations give the person with mental illness equal status in the relationship. So the contribution of people who have experience of mental illness is extremely important to the success of the Project. It is equally important to recognise that this involvement may be stressful, and to ensure that the involvement of people who have experience of mental illness is supported and valued, in order to do no harm, and to model the attitudes and behaviour which the Project seeks to promote.

Buy-in from the mental health sector

Surveys of mental health service users (MIND 1996; Wahl 1997) find that most people's experience of stigma and discrimination occurs in the health services. Collings and Ellis (1997) note that mental health professionals may devalue their client group or particular sub-groups, and general health care providers may also not take them seriously, with physical symptoms seen as psychosomatic rather than somatic, and consequent neglect of physical symptoms. It is therefore essential that efforts to counter stigma and discrimination within the general population are also made within the health services at the same time. It has also been suggested that mental health service workers themselves may be undervalued and marginalised, so it is important that these workers are well informed about efforts to change attitudes in the general population and have the opportunity to contribute.

The power of mass media to influence social attitudes

There is a good deal of evidence that the media has a major role in creating and perpetuating negative stereotypes of people with mental illness (Wilson et al 1999a, 1999b; Allen and Nairn 1997; Wahl 1995; Philo 1994). Most efforts to change public attitudes use the mass media, and studies of other health promotion campaigns affirm its benefit in creating a climate of opinion that is supportive of healthy public policies (Wyllie 1997). However, it is also generally accepted that the media is better at confirming attitudes and slow at changing them. Brown's (1996) review of mass media campaigns concludes that mass media campaigns cannot:

- convey complex information
- teach complex motor skills
- shift attitude change in people who are resistant
- provide the support necessary for motivation of individuals who wish to change their behaviour in adverse physical and social circumstances.

The importance of community action

Other campaigns have demonstrated that, while mass media on its own is unlikely to be successful, campaigns that set realistic outcome criteria and are backed up with community-based education and training are more effective (Barker et al 1993; Reid et al 1995; Wolff et al 1996). While media can be most effective at raising awareness and changing the climate of opinion, changing behaviour requires more direct action. Educational activities at grassroots level provide opportunities to confront stigma and discrimination more directly, to adapt messages to the different cultures that make up New Zealand society and to address obstacles in the real situations in which they occur.

A rights-based approach and equality training in workplaces and other 'controlled' environments

Eagly and Chaiken (1993) identify other influences on behaviour apart from attitudes, such as habits, self-identity and norms. Studies of other efforts to change behaviour, such as the International Labour Organisation's (1999) studies of racial discrimination in the workplace, have found that a rights-based approach, involving enforcement of sanctions against discriminatory behaviour, and redress for victims, is necessary. But legal provisions alone are unlikely to resolve the issue entirely, and it is also important to complement law with education and training. Because training is a voluntary activity, it helps people to understand why legal provisions are in force, and prevents people from falling foul of the law. Once behavioural habits have changed, attitudes follow, and non-discriminatory behaviour becomes the new norm.

Buy-in to the vision, values and principles from a wide diversity of stakeholders, and national/regional co-ordination

The history of this Project in New Zealand since 1996 has also taught us the importance of a shared vision and national/regional coordination. When the Project began, the Ministry of Health was responsible for a national mass media campaign, while Regional Health Authorities were responsible for funding community activities across the four regions. By 1998 it was apparent that this unco-ordinated approach allowed each funder and a wide range of providers to pursue very different approaches, values and principles. Consequently, relationships among stakeholders were very poor. Later that year, the Health Funding Authority took over responsibility for funding both national and regional components of the Project, a national co-ordinator was appointed, and regional plans were amalgamated into one national plan. While the process of developing a shared vision and nationally consistent services was slow and difficult, it has proved to be much more productive, without losing the creativity or cultural diversity of regional providers. The eventual launch of the national mass media campaign in 2000 has given the Project a strong national profile and opened doors for regional and culturally different community activities.

'We cannot assume ... that even where we succeed in influencing attitudes – and even where this coincides with successes in changing law and policy – this will necessarily change behaviour. We will also need to make inclusion happen, at the grassroots – to put enlightened policies, where they exist, into meaningful practice, and to capitalise on the research finding that public education is most effective where it combines educational messages with grassroots approaches that bring users/survivors into contact with different communities.' (Liz Sayce, From Psychiatric Patient to Citizen, 2000)

Model of Change and Strategic Objectives

The scope of Project activities has been developed with reference to the Mental Health Commission's *Map of the Journeys Towards Equality, Respect and Rights for People who Experience Mental Illness* (Appendix 2), the World Health Organization's *Ottawa Charter for Health Promotion* (Appendix 3), and an evidence-based model of change developed for the Project by Phoenix Research (Appendix 4).

The model of change (see Appendix 4) draws attention to the importance of a comprehensive approach, involving work to change both attitudes and behaviour, and identifies key participants in the change process. There is evidence that simply raising awareness is not enough to change behaviour, but that awareness must be supported by practical ways to bring about change in the places where it matters most. For this reason, the plan identifies the main settings where people's behaviour has an impact on the wellbeing of people who have experience of mental illness, such as mental health services and government agencies who have frequent contact with people with mental illness.

Evidence from other efforts to change attitudes towards mental illness and behaviour towards people with mental illness identifies the important roles of:

- people who have experience of mental illness (service users/tangata whaiora)
- mental health services
- media
- community action.

Each of the key components identified in the model has been taken up by one of the strategic objectives identified below. Each objective can also be matched to the *Ottawa Charter* framework. The table sets out the relationships between the theoretical framework of the *Ottawa Charter*, the key components identified by the model of change and the strategic objectives identified in this Plan.

Ottawa Charter	Model of change	Strategic objectives
Building healthy public policy	Changing policy	Change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness, through education and policy development
Creating supportive environments	Mass media advertising Changing attitudes/behaviours of media/opinion leaders Changing climate of public opinion	Change public attitudes and behaviour through media, public relations and community education activities

Ottawa Charter	Model of change	Strategic objectives
Strengthening community action	Changing attitudes/behaviours of public: individuals and groups Empowering people with mental illness and family/whānau	Change public attitudes and behaviour through media, public relations and community education activities Address stigma and discrimination in Māori and Pacific peoples' communities through community education
Developing personal skills	Empowering people with mental illness and family/whānau	Empower people who have experience of mental illness and increase their involvement in the Project
Re-orienting health services	Changing attitudes/behaviours in services/institutions that people with experience of mental illness interact with	Work with the mental health sector to change attitudes and behaviour through education and policy development Develop infrastructure and networks

Strategic objectives

Each strategic objective has both national and regional/local components.

Develop infrastructure and networks

This lays essential groundwork by developing the capacity of service providers, and creating productive working relationships and a common sense of purpose amongst a diverse range of stakeholders. It includes raising awareness of cultural differences, regional and national coordination and workforce development.

Empower people who have experience of mental illness and increase their involvement in the Project

This is also essential groundwork by developing the range of ways in which people who have experience of mental illness are involved in the Project. This includes involving people who have experience of mental illness as advisors, participants and independent providers as well as beneficiaries.

Work with the mental health sector to change attitudes and behaviour through education and policy development

Mental health service providers are essential allies in achieving the Project's aims as well a focus for Project activities.

Change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness, through education and policy development

Government agencies are not only a priority focus for Project activities because they have frequent, direct contact with people who have experience of mental illness, but also because they can be key influencers on other sectors, especially other employers. Change in these agencies needs to be brought about by education at the 'front line', supported by national policies which aim to create a safe and respectful environment for people who have experience of mental illness.

Change public attitudes and behaviour through media, public relations and community education activities

A range of activities is undertaken to create a more supportive environment in the wider New Zealand society by influencing community opinion leaders, local and national media and the general population.

Address stigma and discrimination in Māori and Pacific peoples' communities through community education

The way in which stigma and discrimination is experienced by Māori and Pacific peoples can be different from the way these are experienced by Pākehā people, and community education activities to bring about change in attitudes and behaviour needs to be appropriate to these different experiences and the cultures of each community.

Consistency with National Health Policies

Consistency with national health policies: mental health

‘Zero tolerance of discrimination’ is a requirement of the Mental Health Commission’s *Blueprint for Mental Health Services in New Zealand* (1998): ‘One of the biggest barriers to recovery is discrimination. That is why stopping discrimination and championing respect, rights and equality for people with mental illness is so important. It is as important as providing the best treatment or therapies.’

The importance of this is recognised in the priority population health objectives of the *New Zealand Health Strategy* (Minister of Health: 2000):

‘Improving the health status of people with severe mental illness.

The Government’s major priority for mental health is focusing on improving outcomes for people who have a severe mental disorder – about 3 percent of adults and 5 percent of children and young people. Addressing this issue goes beyond provision of treatment services in secondary and primary settings. It also requires inter-sectoral action to address issues concerning education, housing, stigma and discrimination to help ensure people’s full range of needs is met.’

It is also identified in National Objective 7.1 of the Ministry of Health’s current mental health strategy *Moving Forward* (1997):

‘To increase public knowledge and awareness of mental health issues in order to:

- create a more supportive environment for people living with a mental illness
- help remove the barrier of discrimination and stigma that stops people seeking early assistance and support.’

Standard 18 of the *National Mental Health Sector Standards* specifies the contribution of mental health services in promoting mental health, reducing discrimination and promoting community acceptance of people affected by mental illness.

Competency 6 of the Mental Health Commission’s recovery-based competencies requires a competent mental health worker ‘to understand discrimination and social exclusion, its impact on service users and how to reduce it’.

Consistency with national health policies: public health

The Project is also consistent with the Public Health Directorate’s Mental Health Promotion strategy, *Building on Strengths*. An underlying principle of this strategy is that ‘mental health is a component of all health’, and its goals include ‘a society where people who experience mental illness are valued’. It also complements the New Zealand Youth Suicide Prevention Strategy *In Our Hands/Kia Piki te Ora o te Taitamariki*.

The Public Health Directorate funds other activities which are complementary with the 'Like Minds, Like Mine' Project, such as, Health-Promoting Schools.

Consistency with national health policies: Māori mental health

Mental health is one of eight priority areas for Māori health gain identified in the New Zealand Health Strategy. The Ministry has adopted a new Māori Mental Health Strategy, *Kia Mau Te Hauora Hinengaro*, which aligns the relevant goals of the New Zealand Health Strategy and the *Blueprint for Mental Health Services* with Māori models of wellbeing. *Kia Mau Te Hauora Hinengaro* identifies a set of principles to guide Māori mental health services, and which also apply to the work of this Project:

- Services covered by this strategy will actively acknowledge the special relationship between the Crown and tangata whaiora under the Treaty of Waitangi.
- A Māori mental health strategy should reflect Māori realities and Māori priorities.
- Services covered by this strategy must protect and enhance the cultural and personal safety of tangata whaiora and their whānau.
- Improved effectiveness requires better specification of Māori mental health services and consistently applied standards.
- Māori models of wellbeing require mental health initiatives to occur in an inclusive and integrated manner.
- Capacity-building of Māori service providers is a priority.
- Inter-sectoral and intra-sectoral collaboration is essential to implementing holistic models of care and wellbeing.

Accordingly, the Project has been developed with Māori input at regional and national levels, including the involvement of tangata whaiora, locally through Māori Project providers, and regionally and nationally through the National Advisory Group. This ensures that Māori community needs and views are considered and incorporated through all stages of the Project. Most of the Project funding has been allocated to community-based initiatives, including by Māori for Māori initiatives as well as inclusion in mainstream services. Planning and evaluation of the mass media campaign also takes Māori perspectives into account.

Ko tau raurau, ko taku raurau, ka ora te iwi.

Consistency with national health policies: Pacific health

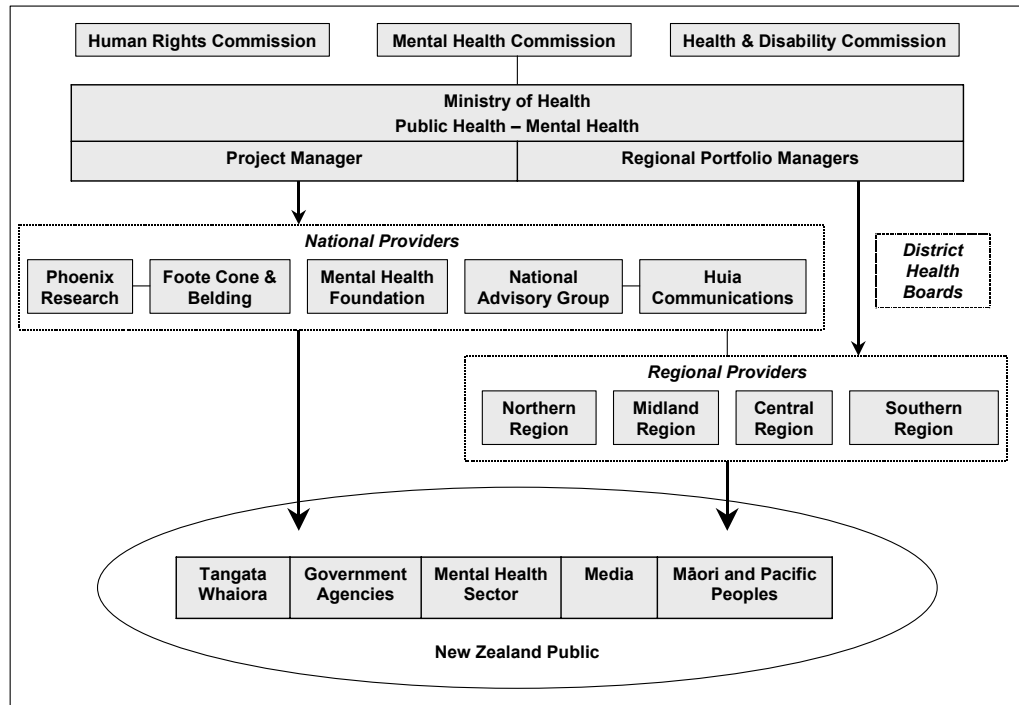
The New Zealand Health Strategy also makes a commitment to reducing inequalities in health for Pacific peoples. A Pacific Health and Disability Action Plan is being developed by the Ministry.

Improving the mental health status of Pacific youth, and improving service capabilities and workforce development are among the priorities identified in the Action Plan.

The Action Plan also sets out the following principles which should underlie the development of health services for Pacific peoples:

- Principle 1: The mana and dignity of Pacific peoples is upper-most in the delivery of health and disability services.*
- Principle 2: Supporting the active involvement of Pacific people in all health and disability services at all levels.*
- Principle 3: Successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities.*
- Principle 4: Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.*

Linkages



Ministry of Health

Strategy and funding

The Ministry of Health is responsible for the strategic management and funding of the Project. These are located in the Public Health Directorate of the Ministry of Health, but the Project Manager is also accountable to the Deputy Director-General, Mental Health, as well as to the DDG Public Health. Regional funding is currently managed by Portfolio Managers in the four former Health Funding Authority regions, pending devolution of funding to District Health Boards. The Project Manager is responsible for the funding of national contracts and co-ordination of national with regional funding and activities.

National co-ordination

Co-ordination of Project strategy and funding is achieved through the Mental Health Promotion Workstream, consisting of members of the Public and Population Health Policy and Strategy Group together with the Regional Portfolio managers. Huia Communications is contracted to maintain regular communications among Project providers and other stakeholders, and to plan and coordinate national events, such as the annual Mental Health Awareness Week and national meetings of the National Advisory Group and Project providers.

District Health Boards

In due course, District Health Boards (DHBs) will assume responsibility for:

- assessing the health needs of their resident populations
- funding and provision of services to meet those needs.

At the time of writing, funding of public health has not been devolved, so DHB roles in relation to this Project are not clear. It will be important in negotiating DHB responsibilities to ensure that the shared vision of the Project is maintained and that national and regional activities continue to be co-ordinated in order to reinforce and add value to each other (see Critical Success Factors, page 4).

People who have experience of mental illness – National Advisory Group²

Achievement of the Project's vision and objectives requires a partnership between people who have experience of mental illness and people who have not shared that experience. As well as being the primary beneficiaries of the Project, people with experience of mental illness may participate in several different roles – primarily as providers or as advisers. A National Advisory Group is funded to advise the Ministry of Health (through the Project Manager and Regional Portfolio Managers) and other providers involved in the Project. Members of the Advisory Group are appointed by people with experience of mental illness who participate in the Project in some way, and who attend regional and national Project meetings.

Mental Health Commission

The Mental Health Commission is required by statute to work with others 'to reduce the stigma associated with mental illness and the prejudice shown to people with mental illness and their families and care-givers; and to eliminate discrimination on the ground of mental illness against people with mental illness and their families and caregivers.'³ To this end, the Commission promotes collaborative efforts within the health and other sectors to reduce discrimination and carries out small projects to complement other initiatives, such as monitoring media reporting on mental illness. The Commission monitors the implementation of the National Mental Health Strategy, including the Project to Counter Stigma and Discrimination Associated with Mental Illness, and works collaboratively with the Ministry's project on:

- implementing joint projects (such as work with the mental health sector)
- sharing information and resources
- advising each other on progress
- consulting on policy and strategic decisions
- consulting on national media and public presentations.

² At its meeting of March 2000 the Consumer Advisory Group adopted the title National Advisory Group.

³ Mental Health Commission Act 1998 s.6 (ii).

Human Rights Commission and the Health and Disability Services Commissioner

Disability, including psychiatric illness, is one of the personal characteristics covered by the Human Rights Act 1993 that cannot be used to justify discrimination. Users of mental health services who believe that they have not been treated fairly by a health service provider also have the right to complain to the Health and Disability Services Commissioner. The Project intends to work more closely with these agencies to promote and protect the rights of people who have experience of mental illness.

Providers

Examples of regional provider activities and initiatives are outlined in the following section.

A list of providers as at May 2001 is attached (Appendix 5).

Achievements To Date

Achievements at a national level

Develop infrastructure and networks

The initial Government response to the recommendations of the Mason Report was to make funds available to implement the Project over a five-year period (1996–2001). Key achievements in the early stages of the Project were:

- 1996 BRC/Te Rangahau Hauora a Eru Pōmare benchmark research to identify public attitudes
- contracting Huia Communications to provide national co-ordination, communication and events management
- 1998 appointment of a National Project Co-ordinator to bring stakeholders together to develop a shared vision and values for the Project
- 1999 adoption of National Plan and ‘Like Minds, Like Mine’ brand
- 2000 Phoenix Research mass media campaign impact evaluation surveys
- regular national hui for providers, National Advisory Group, Māori and Pacific peoples.

Empower people who have experience of mental illness and increase their involvement in the Project

- Development of National Advisory Group to provide strategic advice to the Project.
- Development of the ‘Like Minds, Like Mine’ logo and title.
- Development and national roll-out of ‘Community Voices’ training courses in public speaking for people with experience of mental illness to support Speakers Bureau public speaking programmes.
- Promotion and profiles of people with experience of mental illness within all Project resources.
- Media training for members of the National Advisory Group.
- Young Adult workshops for people aged 18–24 who have experienced mental illness
- Production of *Tu Tangata Motuhake* by the National Advisory Group – the first consumer newsletter produced as a result of the Project.

Work with the mental health sector to change attitudes and behaviour through education

- Ministry's information leaflet for Public Health units.
- Briefings and distribution of Project information pack prior to the commencement of the mass media advertising.
- Sponsorship of 'Like Minds, Like Mine' Award – Promoting Respect, Challenging Discrimination – in association with the Building Bridges non-government mental health service awards.
- Working collaboratively with the Mental Health Commission to pilot the Driving Recovery Forum initiative – a recovery-based approach to mental health service.

Change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness, through education and policy development

- Distribution of Project information pack prior to the commencement of the mass media advertising.
- Development of national organisational policy guidelines and service quality standards in order to create a safe and respectful environment for people who have experience of mental illness.

Change public attitudes and behaviour through media, public relations and community education activities

- Development and promotion of the 'Like Minds, Like Mine' Media Award – an annual award recognising journalistic excellence in the coverage of mental illness issues, attracting 30–35 entries each year since its inception from TV, radio and print journalists.
- Production of a *Media Handbook* to guide journalists and sub-editors in their coverage of mental illness. Distributed annually to all news outlets and journalism training courses.
- Production of a *Constructive Complaining Kit* designed to aid regional providers wanting to lodge complaints about the coverage of mental illness issues with print and broadcasting complaints authorities.
- Provision of media training for all regional providers and supporters involved in the Project – a total of 14 workshops were undertaken around the country.
- Mass media campaign (see box).
- Regular circulation of 'Newsroom' an e-mail media channel that allows Project providers and supporters instant access to topical news items, so where necessary proactive responses can be coordinated and news information shared.
- Co-ordination of awareness events, such as Mental Health Awareness Week, Schizophrenia Awareness Week, and World Health Day – providing media templates, eg, media statements/features/letters to the editor/letters to VIPs and mayors.

- Production of health education resources to support community education activities, for example posters, fact sheets, pamphlets, bookmarks, postcards, balloons, t-shirts, and caps.
- Production of a quarterly newsletter profiling events, activities and people relevant and prominent to the issue of discrimination and stigma surrounding mental illness.
- Circulation of an e-mail broadsheet to all regional providers and supporters involved in the Project, which aims to keep everyone in fortnightly contact with events and issues related to the Project and is a forum for swapping ideas and sharing information.
- Development and launch of the 'Like Minds' website at www.likeminds.govt.nz.

Address stigma and discrimination in Māori and Pacific peoples' communities through community education

- Bringing together Māori and Pacific providers and key stakeholders at national hui and fono to share experiences and develop strategies.
- Use of Māori and Pacific radio to support mass media campaign.
- Development of Māori and Pacific fact sheets and posters to promote key mental illness and discrimination messages.

Impact evaluation of mass media advertising

- Recall of the ads was high.
- Response was positive, and people took up the messages.
- Rate of attitude and awareness change was good, especially compared with other social change ads.
- Māori and Pacific peoples' responses were consistent with mainstream, but Māori demonstrated higher levels of acceptance of people with mental illness – and although Māori had lower recall of the ads, they had more discussion about them.

Achievements at a regional level

Develop infrastructure and networks

- Contracting of 26 local service providers including Māori, Pacific peoples and mainstream.
- Annual national seminar for all regional providers.
- Regional co-ordination meetings and training sessions, eg, facilitation training.

Empower people who have experience of mental illness and increase their involvement in the Project

- Contracting of consumer/tangata whaiora groups as regional providers to the Project.
- Participation of people who have experience of mental illness in local activities as advisers and participants.
- Development of regional Consumer Advisory Groups and District Advisory Groups that are supported by regional providers.
- Development and promotion of the 'Speakers Bureau' – a public speaking programme and source of people willing and trained to speak on their experience of mental illness.
- Wānanga/hui that support tangata whaiora with workshops in art, drama, music and recovery.

Work with the mental health sector to change attitudes and behaviour through education

- 'Hearing Voices That Are Distressing' workshops, led by people who have experience of mental illness, to illuminate the voice hearing experience for non-consumers/tangata whaiora.
- 'Discrimination Awareness' workshops for staff working in mental health.
- Co-ordinating presentations that contribute to the Mental Health Commission's 'Driving Recovery' Pilot Forum.
- 'Debunking the Myths' workshop presented to tertiary students training to enter the mental health workforce.

Change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness, through education and policy development

- Workshops with local offices of key government agencies that have direct and frequent contact with people who have experience of mental illness (eg, WINZ, Police, Courts) in order to increase staff knowledge and understanding of mental illness.
- Submission making to local government authorities regarding supported community housing.

Change public attitudes and behaviour through media, public relations and community education activities

- Work with local media to encourage responsible coverage of mental illness issues locally and generate entries to the 'Like Minds' Media Award; workshops and presentations to journalism courses, and lunchtime media panel discussions.

- Contributing features, letters to the editor, and media statements to local media on topical issues related to mental illness.
- Presentations and key note addresses at national and international conferences.
- Work with key local opinion leaders and organisations, such as businesses, employers, Chambers of Commerce, to ensure policies create a safe and respectful environment for people who have experience of mental illness.
- Activities in schools, eg, 'Media Madness' and 'Break It Down Roadshow', kura kaupapa, churches and marae to increase understanding of mental illness and create a safe and respectful environment for people who have experience of mental illness.
- Awards For Respect – an annual accolade that honours people who support or show respect in their dealings with people who have experience of mental illness.
- Mayors Against Discrimination – an initiative engaging mayors who publicly champion the aims of the Project.
- Rural Mental Health Initiative – aimed at raising awareness of stress, anxiety and depression in farming and rural communities.
- Regional provider newsletters produced and distributed on a regular basis, keeping their stakeholders up to date on activities.
- Wellness Walks/Hikoi held each year during Mental Health Awareness Week that put a public face to the Project.

Address stigma and discrimination in Māori and Pacific peoples' communities through community education

- Work in schools, churches, marae and communities to increase understanding of mental illness and create a safe and respectful environment for people who have experience of mental illness.
- Displays and stalls at key national events and locations, such as the Aotearoa Traditional Māori Performing Arts Festival and South Auckland Markets.
- Promotion of and participation in hui and fono, eg, Best Practices Guidelines For Māori Mental Health Services.
- Production of Māori-specific resources for use when presenting the discrimination kaupapa to rangatahi and tamariki.

Strategic Objectives and Workplan 2001–03

Strategic Objective 1: To develop infrastructure and networks

National activity	Regional activity
Develop Ministry involvement (ie, public health, mental health, Māori and Pacific peoples' health groups). Clarify and develop roles of DHBs and NAG.	Develop linkage between regional activity and DHBs
Fund national communications (eg, newsletters, website) and co-ordination of national events (eg, Mental Health Awareness Week, media awards)	Fund regional communications and co-ordination
Fund national stakeholder meetings/hui/fono	Fund regional stakeholder meetings
Fund national capacity-building*	Fund regional capacity-building where appropriate
Fund national impact/outcome evaluation	Fund regional evaluation where appropriate

Strategic Objective 2: To empower people with experience of mental illness and increase their involvement in the Project

National activity	Regional activity
Fund National Advisory Group of people with experience of mental illness	Fund regional Advisory Group meetings
Fund capacity-building (eg, advocacy)*	Encourage outreach to young people with experience of mental illness
Fund national Community Voices training and co-ordination*	Fund regional speakers bureaux (including Māori and Pacific peoples)

Strategic Objective 3: To work with the mental health sector to change attitudes and behaviour through education and policy development

National activity	Regional activity
Collaborate with MHC, MoH and mental health sector to identify policies and practices which require change*	Input to identification of change issues and process
Fund development of a plan to include issues of stigma and discrimination in sector training curricula	Input to planning process and outcomes
Plan collaborative projects in selected mental health services	Deliver awareness workshops for mental health services staff and training programmes
	Work alongside mental health service providers to educate local authorities and communities, and involve mental health sector in public education activities, eg, Respect Awards, MHAW

Strategic Objective 4: To change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness through policy development and education

National activity	Regional activity
Collaborate with MHC, HRC and HDC to identify stigmatising and discriminatory policies and practices in government agencies*	Input to identification of change issues and targets
Fund implementation of organisational policy guidelines in selected government agencies	Deliver educational workshops in prioritised government agencies

Strategic Objective 5: To change public attitudes and behaviour through media, public relations and community education activities

National activity	Regional activity
Fund a mass media campaign that continues to advance public understanding of stigma and discrimination	
Fund and co-ordinate public relations support for the mass media campaign	Support mass media campaign with local public relations and educational activities
Fund and co-ordinate media education, including constructive complaining and Media Awards	Fund proactive media relationships and campaign activity at local level
Fund and co-ordinate provider training and resources to support community education activity*	Fund planning and delivery of community education activities, including young people
Fund a national creative arts programme, including Māori and Pacific arts*	Fund regional and local creative arts activities
Collaborate with SFNZ and other NGOs representing families to address stigmatising and discriminatory policies and practices*	Work alongside local NGOs representing families to provide community education activities (eg, Respect Awards, Mental Health Awareness Week)
	Fund educational workshops and collaboration with key influencers in other government and community agencies (eg, churches, workplaces) in response to opportunities as they arise

Strategic Objective 6: To address stigma and discrimination in Māori and Pacific communities through community education

National activity	Regional activity
Fund linkages with national Māori organisations and key influencers to develop strategies to address stigmatising and discriminatory policies and practices*	Fund Māori providers' community education activities involving whānau, marae, kura kaupapa, poukai and other community or kin-based groups
	Fund Pacific provider's community education activities involving aiga, churches and other community or kin-based groups

* New national activities

Working Towards the Vision: What Will Success Look Like in the Long Term?

The changes in public attitudes and behaviour that the Project seeks to make will not happen overnight, but over a long period of time, and almost imperceptibly. What will New Zealand be like when we have realised our vision?

How will the lives of people with mental illness be changed?

People who have experience of mental illness that are involved in the Project will:

- be more able to speak of their experiences of mental illness and recovery
- be more able to support other people with mental illness
- have stronger links and networks
- be employed and paid for their contribution to the Project.

People who have experience of mental illness in general will:

- see an improvement in their quality of life
- see people with mental illness that are involved in this Project more able to speak publicly about their illness
- be treated with more respect by mental health services, government agencies, the public and the media
- have greater opportunity to access networks of people with experience of mental illness.

What will we – people directly involved in the Project (ie, people with experience of mental illness, families/whānau, Māori, Pacific peoples, providers, the Ministry of Health and other key stakeholders) – be saying and doing that is different from what we do today?

We will:

- be able to articulate clearly the problems of stigma and discrimination associated with mental illness
- understand that the impact of stigma and discrimination associated with mental illness may vary between groups and this understanding will be reflected in our activity in this area
- have changed our own attitudes and behaviour as a result of being involved in this Project
- practice what we preach in terms of ‘valuing and including people with mental illness’

- be actively involved in education and training concerned with the safety and payment of people with experience of mental illness, and that training will be built into the contracts and policies of the agencies we work for
- the infrastructure already in place for this Project will support the continuation of its work when the funding has ceased.

What will specific target groups (eg, mental health services staff, MPs, police and Government agencies) be saying and doing that is different?

They will:

- have had the opportunity to be trained by people with experience of mental illness and by educators who address issues of language, attitudes and behaviour as they relate to stigma and discrimination against people with mental illness
- have access to resource materials on mental illness
- use more appropriate language when speaking of mental illness
- be more respectful in their treatment of people with mental illness
- build these qualities into their policies, services and contracts.

What will the general public think and do that is different?

They will:

- be more aware of their attitudes and behaviour towards people with experience of mental illness and be more likely to exhibit positive behaviours towards people with experience of mental illness
- have access to accurate information on mental illness
- be aware of the Project and why it is important to New Zealand.

How will the media report mental illness differently?

They will:

- be more aware of stigma and discrimination towards people with experience of mental illness and be less prone to using stigmatising language and reinforcing negative stereotypes
- report stories about mental illness within a more appropriate context
- have access to named mental health spokespeople for this Project.

What will have been the main achievements of reform in this area?

- People with experience of mental illness and providers: upskilling.
- Target groups: attitudes challenged and awareness raised.
- Public: more awareness of discrimination associated with mental illness.
- Media: appropriate reporting and use of language.
- The development of skills among people with mental illness, educators and service providers to challenge stigma and discrimination effectively.
- Change in workplaces, services and other environments to ensure that people with experience of mental illness are treated with equality and respect.
- The rights of people with experience of mental illness are respected by policy-makers, the public and the media.

Appendix 1: What is Process Evaluation Telling Us about the Project to Date (January 2000)?

Evaluation of the Project consists of process evaluation of regional activity and impact evaluation of the national mass media campaign. Process evaluations are available at this stage for the Northern region (Phoenix Research, October 1999), Midland region (Phoenix Research, November 1999), and the Southern region (Nona Milburn, December 1999). Pre-testing of TVC concepts by Phoenix Research (October 1999) is another source of useful information. Impact evaluation will not be available until September 2001, too late to influence critical decisions regarding the future of the Project (although there will be periodical brief surveys at as yet unspecified dates to assess immediate responses to the advertising).

The conclusions drawn from the available evaluations identify some common issues which are important to consider as elements in the future of the Project:

- consumer involvement in the Project
- the role of the mental health sector in the Project
- national/regional co-ordination
- diverse cultural approaches
- effective targeting of activities
- public demand for information about mental illness
- the contribution of healthy public policy to changing attitudes
- workforce development
- strategic alliances.

The evaluations stress the difficulty in establishing such an innovative Project and the long-term nature of the task, and express concern as to how current efforts and achievements will be sustained: 'Not only are we out there ridding the land of weeds, we're trying to also dig it up and make it ready – and then we're trying to plant the seed and grow the seed, and that's what makes the work hard – you're having to do the whole lot in a short space of time ...' (Northern report); 'The campaign needs to persist for years, the change required is enormous, and it will take time and persistence' (Southern report).

They also note that the Project has required new forms of collaboration between mental health and public health services, and new relationships between mental health service consumers and professionals.

Consumer involvement in the Project

Consumer involvement in the Project has evolved during the life of the Project and now takes place in a variety of ways. Although this involvement is considered as a component of current evaluations, there is no comprehensive evaluation of consumer involvement from the consumer viewpoint. Both evaluators have identified different expectations among consumers/tangata whaiora and other providers regarding the role of consumers/ tangata whaiora in the Project: 'There has been mixed feedback about both the level and the nature of consumer involvement in the Project. Consumers/tangata whaiora experiences have been varied, reflecting the quite different levels of involvement they have had and also reflecting different expectations' (Northern report); 'Although there is reference to the Project supporting and resourcing consumer participation there is a perception that this could be more actively encouraged in the workplace. A majority support further consumer participation although some express uncertainty about the place or role for professionals in consumer led action. This provides an important opportunity for exploration and development' (Southern report).

The role of the mental health sector in the Project

The Southern region evaluation reported results of a survey of the mental health workforce in the region. The evaluation report concluded that, while awareness of the Project was high, nurses and clinicians, who are primary points of contact for consumers/tangata whaiora, are less likely to be strongly engaged with the Project. The mental health workforce in general needs to explore and understand the roles of professionals and consumers/tangata whaiora in consumer-led action (Southern report). The report also points out that, although 'the mental health workforce has been identified as a key target group, there have been limited resources and time to specifically focus on this group' (Southern report).

The Northern region report focuses on the experience and viewpoints of public health service providers and consumers/tangata whaiora involved in delivery of the Project rather than the recipients, but reached a similar conclusion: 'Looking at the sustainability of the work commenced by this Project invites some consideration of how other mental health providers could be more included in the future ... One stakeholder ... noted that rather than being seen as part of the problem it would be progressive to also see mental health professionals as part of the solution'.

National/regional co-ordination

A further issue common to both reports is dissatisfaction with the relationship of the national and regional Project activities. Some of the apparent disjuncture in relationships can be attributed to the changing structure of health service purchasing, from four independent regional purchasers with different approaches to service delivery to a single national purchaser with a re-negotiated Project structure and common budget. Both evaluators reported optimism that the 2000 mass media campaign offers 'both an opportunity and necessity for greater co-ordination of the national Project, the regional Project and workplace initiatives' (Southern report), and 'a renewed opportunity to build

confidence in this Project as a national initiative' (pre-testing). Further restructuring of the health sector provides another challenge to effective co-ordination.

Diverse cultural approaches

The expectation that providers would collaborate has raised a number of issues relating to the different dimensions collaboration implies: between public health and mental health; between regional and national; between consumers/tangata whaiora and others; between different cultural traditions. There are significant differences in the ways that mental health/illness are conceived within different cultures, as well as different ways of organising and working. As a result, there was considerable resistance to collaboration, especially from Māori and Pacific providers. However, subsequently providers are seeking increased opportunities to work together. Phoenix discusses whether this should be defined as 'collaboration', 'co-operation', or 'co-ordination' (Northern report). This may reflect increased confidence in each culture's perspective and way of working, leading to a willingness to work together without fear of being subsumed by the majority culture.

Effective targeting of activities

The lack of precedent, the regional structure of purchasing and a desire to be responsive to cultural difference and grassroots initiatives have contributed to a wide variety of approaches. This has provided the benefits of innovation and diversity and the difficulties of a lack of efficiency and consistency. Regional Project providers express concern about lack of leadership and direction (Southern report and Northern report). Although there is still little evidence of what works and what doesn't in this particular field, there is sufficient literature on changing public attitudes and behaviour to add to the experience of providers in order to develop a more carefully targeted approach.

Phoenix has developed a model, linking the experience of destig. Project providers with social change literature, which provides a useful basis for discussion (Midland report).

Public demand for information about mental illness

Phoenix also identifies the lack of information in the general public about mental health and illness as an important factor underlying stigma and discrimination (Pre-testing report and Midland report). This confirms the finding of BRC's benchmark survey 1996. The research shows 'that the public could not address issues of discrimination because they did not know what they were supposed to be discriminating against. There was a strong desire to know more about mental illness, so they could understand what the issues are' (Midland report).

The contribution of healthy public policy to changing attitudes and behaviour

The model of change proposed by Phoenix, consistent with the *Ottawa Charter* framework for health promotion, places increased emphasis on action to change public policy. While this idea is not new to the Project, and some providers are active on the policy front, it is timely to reconsider the effectiveness of this work, and its role in the overall plan.

Workforce development

The lack of experience of many providers in the Project and the need to chart unexplored territory has in some ways slowed the Project from achieving its full potential, but it also means that there is a good body of expertise now among providers, which should be tapped in order to save others from re-inventing the wheel. It is pointed out in the Midland report that it takes ‘an exceptional person to have the range of skills and personality attributes necessary to undertake this type of work. It is likely that most people will have gaps in their skill base and there would seem to be a need to address training needs ...’ (Midland report). Since this expertise also lies with a small number of individuals, should they move on, it may be lost to the Project.

Strategic alliances

In addition to the working relationships that have painstakingly evolved among destig. Project providers, there is also a need to develop similar confident relationships between public health and mental health service providers Northern report, Southern report), and also among other organisations and services that have not hitherto been involved in the Project.

Appendix 2: Map of the Journeys Towards Equality, Respect and Rights for People who Experience Mental Illness

Destination 1: A country in which people with mental illness have the personal power to gain equality, respect and rights

THIS MEANS people with mental illness:

- value their experiences, their strengths and their abilities
- understand their rights and how to protect themselves from discrimination
- know how to find and create opportunities to lead a fulfilling life
- have access to health services which meet their needs.

Paths

- Equip people who experience mental illness with the tools to increase their personal power, to fight discrimination, and to protect themselves from its effects.
- Equip people with mental illness with the tools to maintain or improve their health, wellbeing, relationships, housing, work, leisure and income.
- Support service users/tangata whaiora initiatives that help reduce discrimination.
- Ensure that service users/tangata whaiora do not discriminate against other people with mental illness.
- Research, document, and raise discussion about the personal impact of discrimination on service users/tangata whaiora, and about their successes in reducing it.

Destination 2: A health sector which values people with mental illness and treats them fairly

THIS MEANS people in the health sector understand how its systems, processes and personnel can discriminate against people with mental illness, and put into place measures which ensure:

- adequately resourced mental health services
- equitable access to all health services for people with mental illness
- respect for people with mental illness
- recognition and promotion of their rights
- service users/tangata whaiora influence decision making.

Paths

- Ensure that people with mental illness have equitable choice in all publicly funded health services.
- Actively increase the participation of mental health service users/tangata whaiora at all levels and phases of policy development, funding, and service provision.
- Mobilise the mental health workforce to stop discrimination against people with mental illness.
- Ensure discrimination awareness and related issues are integrated into all education, training and development of health workers.
- Support Pacific peoples to deal with discrimination within the health sector against mental health service users.
- Research, document and raise discussion about discrimination within the health sector including successful ways to reduce it.
- Recognise and reward the best non-discriminatory practices.
- Ensure there are adequate advocacy services and complaints procedures for service users/tangata whaiora in all publicly funded health services.

Destination 3: Laws and practice which uphold the rights of people with mental illness

THIS MEANS there are laws which protect the rights of people with mental illness, and these laws are adequate, understood, promoted and used effectively to deal with discrimination.

Paths

- Identify gaps in legal protection and rights, and promote law reform.
- Equip legal professionals with the tools to provide useful services to people with mental illness.
- Promote better use of existing laws and complaints processes to increase legal protection for people with mental illness in the community.
- Promote better use of existing laws and complaints processes to increase legal protection for people within mental health services.
- Produce information for people with mental illness on legal issues relating to their rights.

Destination 4: Public organisations which are accessible and fair for people with mental illness

THIS MEANS public organisations (eg, Police, Work and Income, Corrections) are aware of the needs and rights of people with mental illness, and put in place measures in their service which ensure:

- respect for people with mental illness
- recognition of the rights of people with mental illness
- understanding of the effects of discrimination against people with mental illness.

Paths

- Disseminate information and provide advice on discrimination against people with mental illness to public organisations.
- Develop anti-discrimination awareness and initiatives in public organisations to ensure equitable service provision.
- Increase co-operation and sharing of information on discrimination issues between public organisations.
- Support Māori to deal with discrimination by public organisations against Māori with mental illness.
- Support and actively assist Pacific peoples to deal with discrimination against Pacific peoples with mental illness.

Destination 5: Private organisations which are accessible and fair to people with mental illness

THIS MEANS private organisations (eg, insurance companies, retailers, landlords, community welfare agencies) are aware of the needs and rights of people with mental illness and put in place measures which ensure:

- respect for people with mental illness
- recognition of the rights of people with mental illness
- understanding of the effects of discrimination against people with mental illness.

Paths

- Disseminate information and provide advice on discrimination against people with mental illness.
- Work with the Human Rights Commission to address discrimination against people with experience of mental illness.
- Identify and use opportunities to raise discrimination issues in private, commercial, and community organisations.

Destination 6: Communities which behave fairly and inclusively towards people with mental illness

THIS MEANS the people of New Zealand will:

- respect the experiences of people with mental illness
- recognise the value of people with mental illness
- understand the negative effects of discrimination against people with mental illness
- take personal responsibility for acting in non-discriminatory ways.

Paths

- Undertake a personal journey to understand discrimination and to challenge discriminatory behaviour.
- Educate people through accurate and accessible information on mental illness and recovery, and through contact with people who experience mental illness.
- Work with the media to improve the representation of mental illness.
- Create strong links between people in the mental health sector in order to present a united voice to the public.
- Use Mental Health Awareness Week creatively.
- Develop non-discriminatory popular language for mental health issues.
- Recognise and counter the double discrimination against Māori with mental illness.
- Recognise and counter the double discrimination against Pacific peoples with mental illness.

Destination 7: Aro ki te ha o te tangata

This destination describes a country which treats Māori with mental illness fairly; it was developed by a group of experts in Māori mental health. This group has listed a wide range of issues which relate to discrimination and moreover cover the need for equity and self-governance for Māori.

The traveller on these journeys need to empower, affirm, and listen to tangata whaiora, and to act positively and be proactive about recognising Māori processes and practices.

Paths

7A Active Māori participation

THIS MEANS ensuring that Māori have the opportunity to make the decisions for, manage, and implement mental health services for Māori.

- Enable cultural assessments for all tangata whaiora to be undertaken by Māori.
- Encourage participation by Māori at all levels and phases of policy making and service delivery.
- Acknowledge and provide for iwi and urban Māori diversity.

7B Positive Māori development

THIS MEANS recognising the need for relevant standards, policies, and practices targeted at delivery of services to Māori.

- Develop the body of knowledge about Māori mental health concepts and service delivery.
- Recognise and encourage successful Māori mental health providers.
- Develop effective relationships between kaupapa Māori and mainstream services to provide the best services for tangata whaiora.
- Recognise the need for kaupapa Māori mental health services.
- Distribute information and provide education on Māori mental health issues.

7C Elimination of disparities

THIS MEANS unlocking the mental health system to ensure Māori priorities have equal consideration in the mental health sector.

- Develop and implement a process that measures the quality of services which tangata whaiora receive.
- Work towards strengthening Māori owned and operated mental health services.
- Accelerate Māori mental health workforce development.
- Provide services that meet tangata whaiora needs.

Appendix 3: Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, Canada, 17–21 November 1986

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands co-ordinated action by all concerned: by

governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means:

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is co-ordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanisation – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services, which refocuses on the total needs of the individual as a whole person.

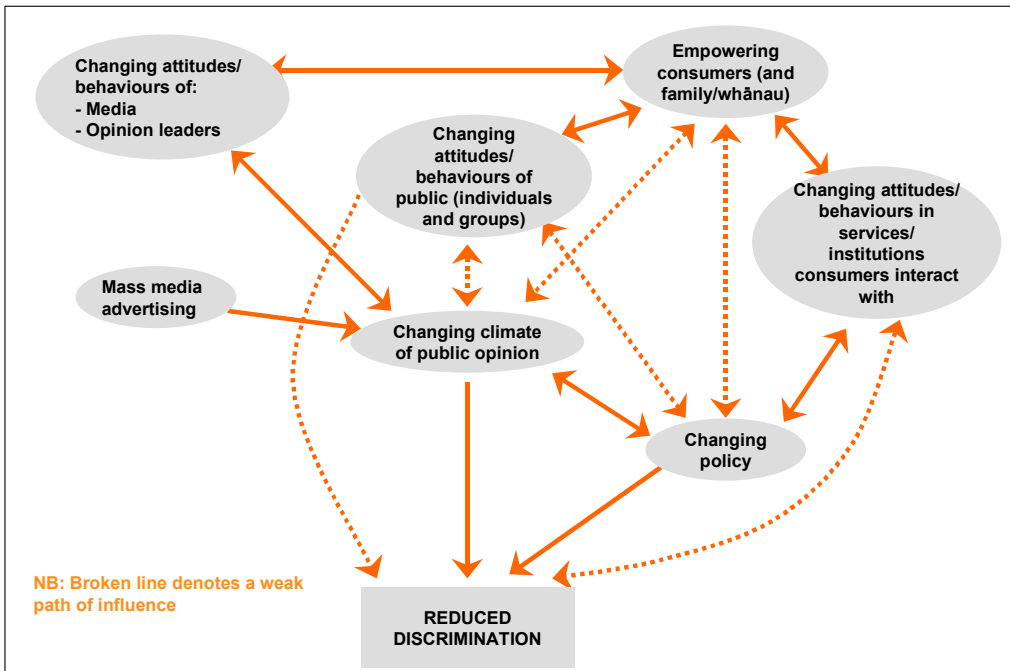
Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the

society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Appendix 4: Phoenix Model of Change for Reducing Discrimination and Stigma Against People with Experience of Mental Illness



Appendix 5: Project Providers at May 2001

Whangarei

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Pacificare, PO Box 23-240, Papatoetoe, Auckland
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