



LIKE MINDS, LIKE MINE  
Whakaitia te Whakawhiri i te Tangata



MINISTRY OF  
HEALTH

MANATŪ HAUORA

# National Plan

## 2003–2005

Project to Counter Stigma  
and Discrimination Associated  
with Mental Illness



2003

**Like Minds, Like Mine  
National Plan 2003–2005**

Whakaitia te whakawhiu i te tangata

### **The Like Minds, Like Mine logo**

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'. 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'.

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MANATŪ HAUORA

## Foreword: Putting Value Back into Madness

To stop discrimination against people with mental health problems we need to look two ways.

This plan looks forward, by creating a vision for a world free of discrimination and some strategies for getting there. But we also need to look backwards to where discrimination starts. People often say it starts with fear, ignorance, misunderstanding, pity or malice. But these are just some of the clothes discrimination wears. Take off all the clothes and we are left with one thing; the devaluing of madness and the entwined assumptions that mad people are full of nonsense and incompetence.



All discrimination stems from the devaluing of madness. The wider community often responds by excluding mad people and madness from its cultural, social, economic and political activities. Friends and families sometimes respond by excluding mad people from intimacy, companionship, social networks and family responsibilities. And mental health services too often use the rituals of diagnosis, mind-numbing treatments and compulsion to devalue the people they are supposed to serve.

To move forward the Like Minds, Like Mine Project needs to challenge the root of discrimination by putting value back into madness. Without denying the pain of madness we need to amplify the voices of people who value madness in different ways. This includes seeing madness as a crisis of being, a reasonable response to trauma, a spiritual awakening, a transformation of identity or a protest against oppression.

This plan shows that the Like Minds, Like Mine Project is growing in its ability to challenge the devaluing of madness by:

- stating that it needs to be led by people with mental health problems
- distancing itself from the more bland approaches to reducing discrimination
- adopting a platform of human rights and the social model of disability and
- increasing its focus on the discrimination in the mental health system.

These are encouraging developments, but if we are ever going to create a world free of discrimination, they need to happen in tandem with a determination to put value back into madness.

A handwritten signature in black ink that reads "Mary O'Hagan". The signature is written in a cursive, flowing style.

**Mary O'Hagan**  
**Mental Health Commissioner**

## Preface

This plan builds on the previous national plans and the evaluation and learning that has occurred during the last five years of the Like Minds, Like Mine project.

At the beginning of the project we knew it would be a challenge to create interest and awareness in the subject of mental illness. As the research findings show, we have been extremely successful in doing this. We know from our regular attitude tracking surveys that people's attitudes are improving. This new plan outlines the need to ensure that the increased awareness and improved attitudes are translated into behaviours that reduce the discrimination that people experience as a result of having a mental illness.



This plan therefore emphasises the importance of working on a public policy and practice level, as well as continuing with the work of persuading people to adopt better attitudes and behaviours. It also outlines a clear philosophy underpinning this approach, which draws on the social model of disability and a human rights approach.

The plan also outlines the key role that people with experience of mental illness have in the project. Their role as leaders and spokespeople in the project is increasing, and this is key to the success of the project's objectives.

The vision, aims and objectives in this plan guide the funding decisions. They also set the direction for the more detailed business, project and programme plans that are developed by those leading the work at the national, regional and local levels.

The vision describes a nation that includes all people with experience of mental illness. We know that this change will not happen overnight. However, if we continue to build on the momentum we have achieved so far, we are hopeful that people with experience of mental illness will increasingly enjoy all the benefits and rights of citizenship, without the barriers created through stigma and discrimination.

A handwritten signature in black ink, appearing to read 'D Matheson'.

**Don Matheson**

Deputy-Director General, Public Health

## Acknowledgements

The discussions and comments that have contributed to the development of this document have been drawn from a wide range of individuals, groups and organisations. Advice and assistance from the following are particularly acknowledged:

- all those individuals and organisations that made submissions as part of the consultation
- the National Advisory Group to the Like Minds, Like Mine project
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- Mary O'Hagan, Hilary Lapsley and Bevan Yee (Mental Health Commission)
- Gael Surgenor and Debbie Peterson (Mental Health Foundation)
- Teresa Pomeroy and Vito Malo (Huia Communications)
- the evaluators on the project, Nona Milburn (Southern region evaluator), Allan Wyllie (Phoenix Research Ltd) and Anne Dowden (BRC)
- Tessa Thompson (Office of Disability Issues)
- Bruce Coleman (Human Rights Commission)
- Ministry of Health regional portfolio managers for the Like Minds, Like Mine project.

Particular thanks go to Helen Gilbert from Desert Nomad Ltd who did much of the drafting and re-drafting on 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)*

A project to counter the stigma and discrimination associated with mental illness was established as a five-year project in response to the 1996 Mason Report (Inquiry under section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services). Since 2001 the Government has maintained the project through public health baseline funding. This document updates the National Plan for the project and outlines the direction of the project for the two years from July 2003 to June 2005.

## Development process for the National Plan

This plan was developed in consultation with the National Advisory Group and other key stakeholders. The plan also draws on information and advice from the evaluators and evaluation reports that have been completed in the last three years. A draft of the plan was made available for public consultation in the first half of 2003. Forty-three submissions were received as part of the consultation, covering most parts of New Zealand.

## Consultation and key points from submissions received

The main points made in the submissions, which have been responded to in this final plan, can be summarised as follows.

- The philosophy and direction of the project needed to be clarified, with particular reference to the social model of disability and a human rights approach. Fuller sections have been written on these in this plan.
- The scope of the plan needed clarification, which as a consultation document featured aspects of three different types of planning: strategic, business and project. The focus and purpose of this plan centre on the strategic direction of the project and key activity areas. The more detailed business and project planning will be done by those working at the implementation level.
- Changes were needed to some of the objectives. The need for a specific objective to address discrimination in mental health services was mentioned in a number of submissions, and some submissions suggested editing changes to clarify the intention of the objective about targeting key audiences. Changes to these objectives have been made based on views expressed in the submissions.

Two communities also responded to the consultation document.

- Asian peoples and refugee and migrant communities responded. The draft plan made explicit reference to Asian communities and their specific needs for culturally appropriate methods. To that extent, these submissions were building on a development that had already been signalled.
- People with experience of alcohol and other drug disorders also signalled their interest in the project. In the terminology of this project people who experience alcohol and other drug disorders are included in the range of groups of people with experience of mental illness.

## Philosophy and Direction of Project

Since the inception of Like Minds, Like Mine, project activities have developed public awareness about aspects of mental illness, with an emphasis on the stigma faced by people with experience of mental illness. As a result, the project can now point to significant and quantifiable changes in attitudes among most sectors of the population. People with experience of mental illness are now asking when they will see accompanying changes in actions and behaviour.

This new plan signals a shift in emphasis towards reducing discrimination, now that the ground work of awareness raising has been done so well. To support this work, the project plan has incorporated a specific human rights model together with the allied social model of disability, which has strong relevance to the discrimination faced by people with experience of mental illness.

### Human rights

*Initiatives to reduce discrimination need to make use of the iron fist of law with the velvet glove of persuasion. (Sayce 2003)*

The Universal Declaration of Human Rights is the contemporary foundation statement for the human rights movement. It was adopted by the UN General Assembly in 1948, and states that ‘recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’.

The declaration makes strong statements about a range of rights, such as:

- All human beings are born free and equal in dignity and rights (Article one)
- Everyone is entitled to all the rights and freedoms in the declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Article two)
- Everyone has the right to life, liberty and security of person (Article three).

New Zealand’s Human Rights Act has its roots in this declaration. Because the Act enshrines many rights in law, there are opportunities to use the law to challenge discrimination against people with experience of mental illness.

The Human Rights Commission was established to assert the dignity and value of all people. Its principals combine:

- education and advocacy about human rights issues, including discrimination
- mediation and other disputes resolution services to resolve human rights complaints
- monitoring and commenting on human rights issues in proposed legislation, district schemes, personnel practices and procedures, etc.

People with experience of mental illness have not used the Human Rights Act to any great extent, partly out of lack of knowledge about how to complain effectively. The Human Rights Commission is a potentially powerful new ally in the campaign against discrimination.

We know that attitudes are changing. But while attitudes and behaviour are strongly linked, in the end it is behaviour change that is desired, and this is the domain of the human rights movement. Once behavioural habits have changed, attitudes follow, and non-discriminatory behaviour becomes the new norm.

## **Social model of disability**

New Zealand has an overarching policy on disability issues in the New Zealand Disability Strategy. The strategy uses the social model of disability, which analyses disability as a process which happens when one group of people create barriers by designing a world only for their way of living. Disabling attitudes and behaviour are a social problem of barriers to participation, and these barriers are the cause of disability. This is in contrast to the medical model, which equates mental illness with disability, and locates the problem within the individual who has experience of mental illness.

Disabled people face systematic discrimination in the way society and its institutions are organised, by the way the environment is constructed and by the attitudes, values and beliefs that develop as a result of the systematic exclusion of disabled people from mainstream society.

A key implication of the social model of disability is that those who are excluded must participate in the design and implementation of solutions to the problem. For the Like Minds project, this means that people with experience of mental illness have a central role to play in the leadership, management and operation of project activities.

## **Barriers to participation**

The barriers placed before disabled people and people with experience of mental illness are similar in their effects.

- Special/segregated provision in education, housing, employment, transport and many other services means that people with experience of mental illness are separated socially from other people.
- Disabled people are on average three times more likely to be out of work than non-disabled people, and many will have to rely on benefits for their basic income.
- Poverty is the greatest disabling factor for the majority of disabled people – and that includes people with experience of mental illness.
- Many people with experience of mental illness can not get the information they need to participate in society, either because their education levels have been limited, or because the information is not provided in accessible formats.

The Like Minds project will benefit from recognising that all disability groups have much in common. All are potential allies, because of their collective knowledge and experience of a social and political rights-based approach. Some differently-abled groups have high

rates of co-existent mental illness. While many groups have different ideas about how well the 'disability' label fits, the issues of a disabling society are largely the same: 'Who we are is OK, what happens to us is not.'

The solution lifts the blame from the shoulders of disabled people and places it squarely on to society, thereby liberating and politicising disabled people to challenge society to remove those barriers. It comes from disabled people's own experiences and is the basis for all organisations run and controlled by disabled people who promote rights, equality and inclusion for all people. The fusion of human rights and a social model of disability occurred in the 1990s, when disability was redefined as:

*the disadvantage or restriction of activity caused by contemporary social organisation which takes no or little account of people who have ... impairments and thus excludes them from the mainstream of social activities.*  
(Oliver 1990)

This new conceptual understanding has appealed to and accompanied a growing civil, political and human rights movement led by disabled people, including people with experience of mental illness, in countries across the globe.

Internationally some service user groups are exploring a social model of madness which looks at how society constructs and defines the notions of 'madness' and 'distress' - and discriminates accordingly (Beresford 1997). This model is increasingly examining:

- the social causes of our madness and distress;
- the medicalisation of our experience and distress;
- the destructive and discriminatory response to it from both psychiatry and broader society;
- the need for a social response to the distress and disablement which survivors experience, addressing the social origins and relations of their distress, instead of being restricted to people's individual difficulties; and
- the need for survivor-led alternatives to prevent distress and offer appropriate support for survivors (Beresford, Gifford and Harrison, 1996).

This accords with the experience of people with mental illness, who find that New Zealand society is structured in a way that fails to recognise that not everybody has or wants stable moods and perceptions. Preliminary analysis of the Like Minds survey of discrimination against people with experience of mental illness suggests that the research will yield useful information in this area.

The success of Like Minds or any anti-discrimination campaign is dependent on the ability to recognise commonality, and the subsequent building of collective strength. The Like Minds plan, the programme and all training activities need to incorporate and communicate an understanding of the New Zealand Disability Strategy and the social model of disability, and how these relate to discrimination against people who experience mental illness. This will give greater collective strength to the Like Minds project and to other allied anti-discrimination programmes.

# Vision, Aims, Critical Success Factors

## Vision

A nation that values and includes all people with experience of mental illness.

## Aims

- Enable all people with experience of mental illness to gain equality and respect and to enjoy the same rights as others.
- Change public and private sector policy to value and include all people with experience of mental illness.
- Create greater understanding, acceptance and support for all people with experience of mental illness.

## Critical success factors

These factors are the elements that are most conducive to a successful project, and they are listed in order of importance.

For the project to succeed it is critical that:

1. project activities are aligned to the project philosophy and direction
2. project activities focus on the specific issues in the objectives
3. the ability of people with experience of mental illness to advocate for their rights is developed and enhanced
4. the project enlists the support of a broad range of institutional allies and key opinion leaders
5. project participants increase their capacity to advocate for material changes to discriminatory policy and practices
6. the project continues to influence and improve general public attitudes through mass media television and radio advertising
7. project participants further develop their relationships with the media to advocate for the anti-discrimination agenda.

# Objectives, Strategies and Activities

## Summary of objectives

1. Engage the leadership and participation of individuals and groups of people with experience of mental illness.
2. Engage supporters and allies as partners.
3. Advocate for non-discriminatory policies and practices.
  - 3.1 Advocate for non-discriminatory policies and practices within organisations that are responsible for housing, education, employment, income and access to goods and services.
  - 3.2 Advocate for non-discriminatory policies and practices within organisations that are responsible for mental health services.
4. Use mass media, community education and other means to improve the social inclusion of people with experience of mental illness.
5. Develop specific approaches by Māori, in recognition of their status under the Treaty of Waitangi, to address the discrimination faced by Māori with experience of mental illness.
6. Develop specific approaches for people from different cultures, ethnic groups and age groups.
7. Develop and strengthen infrastructure to improve co-operation and co-ordination to achieve the aims of the project.

## Objective 1: Engage the leadership and participation of individuals and groups of people with experience of mental illness

Leadership and participation by people with experience of mental illness at all levels of the project are critical to its long-term sustainability and eventual success. People with experience of mental illness are experts by virtue of their experience, they have a living interest in reducing discrimination, and they have an important role in challenging the stereotypes and unfair policies and practices that exist. The leadership abilities of people with experience of mental illness must be valued, encouraged and developed so that they are increasingly employed or contracted, and remunerated for their skill and contribution in the project.

### *Proposed strategies*

- Develop and support activities that increase the leadership and participation of people with experience of mental illness at all levels of the project.
- Develop and support national and regional activities that ensure the voices of Māori people with experience of mental illness are heard.
- Develop and support national and regional activities that ensure the voices of Pacific people with experience of mental illness are heard.

### *Suggested activities*

National	Regional
<p>Fund a national advisory group.</p> <p>Recruit, train and employ people with experience of mental illness to work on the national components of the project.</p> <p>Support the Mental Health Commission project to develop media spokespeople with experience of mental illness.</p> <p>Fund the development of training and resources for work delivered by people with experience of mental illness.</p> <p>Build the capacity of existing initiatives such as Speakers Bureau and Hearing Voices that are Distressing workshops.</p> <p>Fund the development of training and resources specific to work delivered by Māori with experience of mental illness.</p> <p>Fund the development of training and resources specific to work delivered by Pacific people with experience of mental illness.</p> <p>Review and audit the extent of leadership and participation by people with experience of mental illness and consumer / tangata whai ora groups in the project.</p> <p>Ensure the perspective of people with experience of mental illness is included in all talks, presentations and seminars about the project.</p> <p>Explore ways of ensuring the voices of Asian people with experience of mental illness are heard.</p>	<p>Recruit, train and employ people with experience of mental illness to work on the regional components of the project.</p> <p>Support groups of people with experience of mental illness to develop programmes and activities that reduce discrimination.</p> <p>Fund training for presenters and speakers through the Community Voices training resource.</p> <p>Support opportunities for delivering Hearing Voices that are Distressing workshops by trained facilitators.</p> <p>Ensure the perspective of people with experience of mental illness is included in all talks, presentations and seminars about the project.</p>

## Objective 2: Engage supporters and allies as partners

The project needs allies and supporters to help achieve the vision. Reducing discrimination is a complex task, and allies and supporters can offer a broad range of knowledge, experience, skills and resources.

Nationally, the project needs close working relationships with key allies such as the Mental Health Commission, the Human Rights Commission and the Office for Disability Issues. Locally, it needs partnerships with supporters who are family/whānau, and workers in government, non-government and mental health organisations. A key requirement of all supporters and allies is a commitment to work in partnership with people with experience of mental illness.

### **Proposed strategies**

- Develop relationships and activities with potential supporters and allies to reduce discrimination.
- Enter into agreements with key supporters and allies for joint approaches.

### **Suggested activities**

National	Regional
<p>Develop a memorandum of understanding between the Office of Disability Issues and the project on how to work in partnership to implement the New Zealand Disability Strategy.</p> <p>Review the memorandum of understanding with the Mental Health Commission in light of the new objectives of the national plan and the Mental Health Commission work programme.</p> <p>Review the memorandum of understanding between the project and the Human Rights Commission in light of the new objectives of the national plan and the Health Research Council's National Plan of Action.</p> <p>Develop guidelines for how supporters, allies and contracted providers can work in partnership with people with experience of mental illness.</p>	<p>Develop relationships and activities to reduce discrimination with groups that have common interests with the project, such as:</p> <ul style="list-style-type: none"> <li>• disability rights and resource groups (including disability resource centres and CCS)</li> <li>• tenancy protection groups</li> <li>• people's resource centres</li> <li>• benefit rights organisations</li> <li>• local Māori groups focused on rights</li> <li>• trade unions that work with people with experience of mental illness, such as the Nurses Organisation, Service Workers Union and the Public Service Association</li> <li>• community-rights groups such as citizens' advice bureaux</li> <li>• professional bodies whose members interact with people with experience of mental illness</li> <li>• church-based social justice organisations</li> <li>• mental health service organisations (including District Health Boards, and providers of supported housing and employment)</li> <li>• local authorities: most city councils have groups whose broad goal is to work towards social inclusion</li> <li>• other community groups focused on reducing inequalities</li> <li>• community law centres</li> <li>• women's groups.</li> </ul>

## Objective 3: Advocate for non-discriminatory policies and practices

### 3.1 Advocate for non-discriminatory policies and practices within organisations that are responsible for housing, education, employment, income and access to goods and services

*Initiatives to reduce discrimination need to make use of the iron fist of law with the velvet glove of persuasion. (Sayce 2003)*

Change needs to occur within organisations and institutions, as well as among individuals. To reduce organisational and institutional discrimination the project needs to advocate for people’s rights within housing, education and employment institutions, including income service agencies. Private sector organisations that offer goods and services also need to change. Organisations must recognise the need for change and insist on improved policy and practices.

#### **Proposed strategies**

- Find out where discrimination is occurring.
- Advocate for changes to systems that create or maintain inequality by discriminating and excluding people with experience of mental illness.
- Encourage the use of existing mechanisms to redress discriminatory actions.
- Support people with experience of mental illness to advocate for themselves.

#### **Suggested activities**

National	Regional
<p>Collect and analyse information and evidence on where and how discrimination is occurring.</p> <p>Collect information on the discrimination experienced by Māori and Pacific people who have experience of mental illness, and other groups who may have particular issues.</p> <p>Develop and implement strategies for changing discriminatory policies and practices.</p> <p>Update the literature review of effective practice to reduce discrimination.</p> <p>In partnership with the Human Rights Commission, produce a training resource for people with experience of mental illness to become trainers of consumer rights advocates.</p> <p>Support the development of training and resources to assist with advocacy on discriminatory issues.</p> <p>Work in partnership with other international organisations, particularly around policies and practices in international organisations, that affect the lives of people living in New Zealand (eg, access to insurance).</p>	<p>Support national surveys and other methods that collect information and record evidence on where and how discrimination is occurring.</p> <p>Advocate for changes to systems that discriminate and exclude people with experience of mental illness.</p> <p>Advocate for changes to systems and practices within organisations that provide housing, education, employment, child and family services and public services to reduce inequalities.</p> <p>Develop and support people with experience of mental illness to advocate for themselves to change systems and practices.</p> <p>Lend support to groups led by people with experience of mental illness that are already working in treatment and support services to reduce the discrimination people face.</p> <p>Encourage the use of existing mechanisms (such as the complaints processes of the Human Rights Commission, the Health and Disability Commissioner, Tenancy Tribunal and others) to redress discriminatory actions.</p> <p>Support Human Rights Commission training for people with experience of mental illness to advocate for their rights.</p>

### 3.2 Advocate for non-discriminatory policies and practices within organisations that are responsible for mental health services

Surveys of mental health service users (eg, Wahl 1995) find that most people’s experience of stigma and discrimination occurs within these 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 fail to take them seriously, seeing physical symptoms as psychosomatic and consequently neglecting them. Mental health service workers themselves may be undervalued and marginalised, so it is important that they have the opportunity to contribute to improving the status of people with experience of mental illness – which will consequently improve their own status.

#### ***Proposed strategy***

- Support groups that work to reduce discrimination in mental health treatment and support services (particularly those led by people with experience of mental illness, such as consumer networks).

#### ***Suggested activities***

<b>National</b>	<b>Regional</b>
<p>Develop closer working relationships with the District Health Board regional mental health networks.</p> <p>Support forums to explore how the project can work more effectively with mental health services to reduce stigma and discrimination.</p> <p>Increase understanding of Standard 18 of the mental health standards.</p> <p>Develop opportunities for advising on and contributing to the implementation of Standard 18.</p>	<p>Advocate for changes to systems that discriminate and exclude people with experience of mental illness.</p> <p>Develop and support people with experience of mental illness so that they can advocate for themselves.</p> <p>Lend support to groups led by people with experience of mental illness that are already working in treatment and support services to reduce the discrimination people face.</p> <p>Encourage the use of existing mechanisms, (such as the complaints process of the Health and Disability Commissioner) to redress discriminatory actions.</p>

## Objective 4: Use mass media, community education and other means to improve the social inclusion of people with experience of mental illness

*We cannot assume ... that even where we succeed in influencing attitudes ... this will necessarily change behaviour. We will also need ... to put enlightened policies, where they exist, into meaningful practice. (Sayce 2000)*

The media have 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 et al 1994). Most efforts to change public attitudes use the mass media, and studies of other health promotion campaigns confirm its benefit in creating a climate of opinion that is supportive of healthy public policies (Wyllie 1997).

While the media can be effective at raising awareness, changing behaviour requires more direct action. Educational activities with priority groups and opinion leaders go beyond broad awareness raising and provide opportunities to:

- address stigma and discrimination more directly
- adapt messages to the different cultures within New Zealand society
- address obstacles in the real situations in which they occur.

### Proposed strategies

- Work with news and mass media to foster and promote informed and non-discriminatory reporting of mental illness.
- Develop community action, advocacy, education, training and community activities that are specific to priority audiences, to reduce discrimination.

### Suggested activities

National	Regional
<p>Educate journalism students about discrimination against people with experience of mental illness.</p> <p>Develop education resources for journalism schools.</p> <p>In partnership with the Carter Center (USA), jointly fund two annual NZ Carter Center journalism fellowships.</p> <p>Provide training and support for working with the media for project providers and supporters, especially people with experience of mental illness.</p> <p>Co-ordinate national and local media monitoring.</p> <p>Research and test concepts for a third phase of mass media advertising.</p> <p>Present project outcomes via conferences and journals (nationally and internationally).</p>	<p>Identify key target audiences and rationales for working with them.</p> <p>Develop and implement activities with local priority audiences to reduce discrimination.</p> <p>Develop community education approaches that work for the different target audiences.</p> <p>Increase Māori input into local strategies.</p> <p>Support capacity building for people with experience of mental illness to be involved in this work.</p> <p>Monitor national and local media, and co-ordinate responses within regions by acknowledging enlightened coverage and complaining about inaccurate and stigmatising reporting.</p> <p>Develop working relationships with local journalists.</p> <p>Support spokespeople to talk to the media.</p>

**Objective 5: Develop specific approaches by Māori, in recognition of their status under the Treaty of Waitangi, to address the discrimination faced by Māori with experience of mental illness**

Māori have a specific cultural context for understanding mental illness and the discrimination faced by Māori with experience of mental illness. They also face multiple forms of discrimination, as well as needing to address their own attitudes towards people with experience of mental illness. The principles of partnership, protection and participation, in accordance with the Treaty of Waitangi, need to be applied and demonstrated at all levels of the project.

***Proposed strategy***

- Support opportunities to increase the leadership and participation in the project by Māori who have experience of mental illness and their whānau support.

***Suggested activities***

<b>National</b>	<b>Regional</b>
<p>Organise annual national Like Minds, Like Mine provider hui.</p> <p>Support the development of resources and training specific to the needs of Māori working on the project.</p> <p>Support work to scope and better understand the needs of Māori in relation to the discrimination they experience associated with mental illness.</p> <p>Identify Māori ‘champions’ for the project.</p>	<p>Develop relationships and activities with Māori who have experience of mental illness, to increase their leadership and participation in the project.</p> <p>Develop the ability of whānau, hapū and iwi whose members have experience of mental illness to support the project’s goals.</p> <p>Identify role models and spokespeople.</p>

## **Objective 6: Develop specific approaches for people from different cultures, ethnic groups and age groups**

Cultural and ethnic groups have specific contexts for understanding mental illness. As well as needing to address their own attitudes towards people with experience of mental illness, people from different ethnic groups also face multiple forms of discrimination. The project needs to develop approaches that recognise the cultural context of stigma and discrimination for Pacific and Asian communities, and for young people as a population group.

### ***Proposed strategies***

- Develop effective relationships to challenge discrimination among Pacific and Asian communities.
- Engage young people with experience of mental illness to challenge the discrimination they face.
- Develop activities to address discrimination faced by marginalised populations that have experience of mental illness.

### ***Suggested activities***

<b>National</b>	<b>Regional</b>
<p>Support the development of resources and training specific to the needs of Pacific people working on the project.</p> <p>Develop understanding of the issues related to discrimination associated with mental illness in other ethnic groups, including Pacific and Asian communities.</p> <p>Engage young people with experience of mental illness about the discrimination they face.</p> <p>Seek advice on how best to meet the needs of groups with other impairments, to ensure information and education programmes are accessible.</p>	<p>Develop relationships and activities with Pacific people who have experience of mental illness, to increase their leadership in the project.</p> <p>Develop relationships and activities with the other identified groups to increase their participation in the project.</p>

## **Objective 7: Develop and strengthen infrastructure to improve co-operation and co-ordination to achieve the aims of the project**

The project needs a comprehensive theoretical and organisational capability framework for its ongoing anti-discrimination work. Organisations funded to work on the project need to build, orientate, train and support those working on the project, including people with experience of mental illness. People who are actively working within the project will model the non-discriminatory attitudes and behaviours of acceptance and inclusion that the project seeks to encourage in others.

### ***Proposed strategies***

- Improve co-operation and co-ordination between project-funded activities across levels (local and regional) and between regional and national activities.
- Develop comprehensive frameworks for the project to guide the effective development and use of resources.
- Support the infrastructure development of groups of people with experience of mental illness to work on the project.
- Monitor and evaluate the effectiveness of project activities to ensure they are achieving the project aims.
- Measure the progress towards a comprehensive approach.

### ***Suggested activities***

<b>National</b>	<b>Regional</b>
<p>Explore and develop a comprehensive approach for the project to better understand the 'how and why' of effective strategies and activities aimed at reducing discrimination.</p> <p>Continue annual national conferences and other planning and information-sharing forums.</p> <p>Organise workforce-training events on relevant topics such as programme planning and how to measure your progress.</p> <p>Monitor and audit national and regional delivery of the project.</p> <p>Produce and distribute a quarterly project newsletter.</p> <p>Produce and distribute monthly electronic broadsheets to update key stakeholders on project work.</p> <p>Maintain and regularly update the project's web site.</p>	<p>Develop agreements on joint approaches specific to Māori, their whānau, hapū and iwi (eg, courses delivered for government agencies should be jointly delivered by Pākehā and Māori).</p> <p>Develop partnerships and joint plans, and agree on ways of co-operating with project providers on common objectives.</p> <p>Develop partnerships and agree on ways of co-operating with key supporters and allies, including local consumer networks and people with experience of mental illness.</p> <p>Support the infrastructure development of groups of people with experience of mental illness, to help them become leaders in the project.</p> <p>Develop relationships with representatives from Asian peoples and refugee and migrant communities.</p> <p>Organise regional provider planning and information-sharing meetings.</p> <p>Monitor and audit progress.</p>

## **Appendix 1: Progress from 2001–2003**

Between 2001 and 2003 people with experience of mental illness have become increasingly involved in leadership and other aspects of Like Minds, Like Mine, including input into the overall strategic direction of the project through the National Advisory Group.

Innovative community action and education activities were also implemented, including:

- programmes, including training, for people with experience of mental illness to work as educators have proven to be particularly powerful
- annual award-for-respect ceremonies (many held in local mayoral council chambers) for people who showed respect throughout the year, and many other innovative awareness raising and community action programmes
- education and training workshops, mostly run by or involving people who have experience of mental illness, to staff in government organisations including the Police, Housing New Zealand, Ministry of Social Development (including Work and Income support areas) and mental health services
- a national discrimination survey recording people's experiences of discrimination in relation to their mental illness (over 780 written responses were received)
- increased advocacy through the media by spokespeople giving a service-user perspective (in both news and feature articles), education presentations in journalism courses, and funding of journalism research fellowships through the Carter Center (USA)
- production of training and education resources, including the Community Voices training kit and the Facilitation Handbook.

### **Success in advertising and social marketing**

Two phases of mass media advertising using television and radio were implemented. Based on the attitude tracking surveys the predominant pattern was of significant improvements in general public attitudes as a result of both phases of mass media advertising. The recall of the advertising was consistently high (87 percent for phase two), and even when off air awareness was maintained at high levels. Significantly, 62 percent of people surveyed reported discussing the advertising at least once with someone else. People also said that the messages they took out of the ads were: give support/don't discriminate (50 percent); it affects a wide range of people (48 percent); and it's not shameful, it's an illness like any other (25 percent).

The project achievements in the area of advertising and social marketing were also recognised by the New Zealand EFFIE awards for effectiveness in advertising, and two awards at the New Marketing Magazine Awards, including the overall Supreme Marketing Award.

## **Views of people with experience of mental illness**

Research sought feedback on the Like Minds project from people with experience of mental illness through in-depth interviews with 20 key informants, 266 self-completed questionnaires and focus groups with 42 Pacific people.

The advertising was seen to be having an impact. Over 80 percent of survey participants felt the ads were helping to reduce stigma and discrimination associated with mental illness. The main impact was seen to be increased awareness and understanding.

Other parts of the project were also seen to be having an effect. Key informants mentioned a range of impacts, including the greater participation of people with experience of mental illness in the project. Many also reported reduced stigma and discrimination. Considerable numbers of survey participants reported having noticed or experienced reduced stigma and discrimination associated with mental illness over the last three years in a range of organisations and groups.

Over half of survey participants reported levels of reduced stigma and discrimination from family, mental health services and the public. A little less than half reported a reduction from WINZ, while around a third mentioned a reduction within the Police, Housing New Zealand and the media.

## Appendix 2: Learning from project evaluations, 2001–2003

### Introduction

This appendix summarises six recent evaluations of the Like Minds, Like Mine project. The summary is intended as a resource for project leaders (funders and providers), to guide their project and business planning.

The evaluation findings summarised here were produced for varying purposes, and sought to discover different things about the campaign, covering geographically distinct regions. The evaluation findings were taken from the following sources:

- *Evaluation of the Project Activities in the Central Region*, Anne Dowden (BRC) and Tim Rochford (independent Māori researcher), BRC Marketing and Social Research, September 2002
- *Evaluation Report to the Ministry of Health on the Like Minds Like Mine Government Agency Project*, Nona Milburn, July 2002
- *Impacts of the National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness: Survey 4*, Shaun Ackroyd and Allan Wyllie, Phoenix Research, December 2002
- *Key Learnings from the Pilot Phase of the Like Minds Project*, Allan Wyllie, Phoenix Research 2002
- *Learning from the South Island Evaluation*, Nona Milburn, November 2002
- *People with Experience of Mental Illness: Perceptions of the Like Minds project*, Shaun Ackroyd and Allan Wyllie, Phoenix Research, March 2003.

In what follows we refer to these as BRC, Milburn and Phoenix.

The principal issues to emerge from the evaluations are grouped under the following headings. Note that because this paper represents a summary of six evaluations, the following headings do not necessarily relate to the headings used in any individual report.

1. Project model, theory and implied strategies
2. Provider project management
3. Project activities
4. Specific targets
5. Funder activities

### 1. Project model, theory and implied strategies

The Like Minds project does not follow a single theory, nor do project participants agree on a single model of change. As a consequence project providers engage in a wide range of activity, some of which need to be re-considered. BRC explicitly found that the diverse perspectives of project teams are a barrier to progress. That finding was similar to the findings of the Phoenix evaluations of the northern and midland regions.

### ***Community development and social inclusion***

Community development is a component of health promotion, and the southern evaluation identified that the lack of an explicit community development strategy in the beginning of the project caused subsequent problems. Milburn notes that Sayce (2003) recommends social inclusion strategies for the long-term goals, rather than focusing on short-term events.

### ***Public health or mental health?***

BRC identified activities in the central region that promoted consumer wellness and self value, and which were being delivered as part of the Like Minds project. The report noted that this has both advantages (it allows economic use of limited resources, and enables people with existing networks and knowledge to work on the Like Minds project in conjunction with other roles) and disadvantages (it tends to make the parameters of the project unclear). BRC also noted that the broad variety of perspectives has given rise to tensions, or misunderstandings about the progress and objectives of the project. Phoenix also discussed this issue, and asked whether some providers were using public health funding (ie, Like Minds funding) to plug gaps in mental health service funding.

### ***Not general mental health promotion***

Phoenix also explained that the Like Minds project is not a component of general mental health promotion, and recommended that mental wellbeing programmes and personal health programmes should be funded by mental health services rather than by the Like Minds project. BRC noted that providing educational sessions such as mental health awareness workshops is also a role of mental health promotion services.

### ***Strategic planning***

BRC found a need for careful strategic planning for the programme of activities that link the project goals and objectives directly to the providers/teams' activities. This planning would ideally include processes to monitor whether the activities met the objectives they were meant to meet. A process of this nature would also tend to highlight whether any activity did not contribute to any project objective, or whether there were overlaps, with too many activities focusing on the same objective.

### ***Separate delivery for Like Minds***

Phoenix noted that some providers combined Like Minds activities with the delivery of other mental health services. They recommended separate delivery in order to create more impact for the Like Minds project. Milburn pointed out that the district advisory group model in the South Island was set up solely to deliver Like Minds, but that at times, in some groups, other priorities for people with experience of mental illness took over (such as drop-in centres).

### ***Human rights***

Adopting a human rights model is consistent with community development, and is recommended.

### ***Activities must be targeted***

A lesson from social marketing is to target efforts in just one or two places: a scatter-gun approach probably will not have enough impact on anything to make a real difference, according to the Phoenix evaluation. To achieve change in policies, behaviours or attitudes, the whole project needs to adopt strategies that focus on just a few targets.

### ***Lack of experience and possible resistance to change***

In its early days the project suffered from a lack of guidance. Providers had varying experience at strategic project planning, and some lacked experience in undertaking this type of project (reducing stigma and discrimination, rather than promoting good mental health). Consequently, some providers developed initiatives that were based on their current strengths and skills, and did not always have a clear rationale and specific strategy for meeting the project's objectives. Having put time and resources into developing initiatives it would be understandable if providers resisted changing to more effective strategies, especially if they have employed staff with particular skills and interests.

### ***Focused, discrete teams***

BRC recommended that providers use specific Like Minds teams, rather than a large, undefined consortium of individuals.

## **2. Provider project management**

### ***Project management – providers***

#### ***Performance gaps***

The evaluations noted that there are good people doing good work on the project. However, many providers need to improve the quality of their project management: record-keeping, documentation and reporting of processes and outputs are important components of effective project management. Some providers are very tightly focused, but given their resourcing this is a realistic approach. A relevant issue here is that the service specifications have many outputs, and while some providers have a great deal of control over what is included in their service specifications, others do not feel they have the same control, or they feel obliged to include activities under each National Plan objective. (This point is also discussed in the final section of the paper, on funder project management and co-ordination.)

When there are changes in provider staff there needs to be sufficient institutional knowledge for new staff to benefit from previous work done on the project. Providers are often seen as working in too many areas, without sufficient focus, and it was recommended that providers reduce the spread of their activities and prioritise key target groups.

The gap in local input to national activities was also noted as an area for improvement.

#### *Right people, clear roles*

The evaluations identified the need for providers to have the ‘right’ people. However, for good people, clarity of roles and responsibilities are keys to success. Milburn noted tensions between long-term and short-term goals for some participants.

#### *Independence from the state*

Milburn also noted issues arising from the project’s funding source: it can be difficult to criticise the state when accepting funding from it.

#### **Participation of specific groups**

##### *People with experience of mental illness*

All evaluations recommended increased participation of people with experience of mental illness in the project. They also discussed the need for training and professional development to ensure full and effective participation. The shortage of people with experience of mental illness who have the appropriate skills and experience, and who are attracted to work on the project, was identified as a barrier to progress by BRC, and was seen as a priority issue by Milburn. Phoenix noted that this is still a new field, which accounts for the relative lack of national leadership. BRC noted that building capacity has three aspects: recruitment, professional development and retention.

##### *National Advisory Group*

The National Advisory Group is seen as a positive feature of the project by people with experience of mental illness, but it needs to become more active and visible in the regions. The processes of selection, responsibility and accountability are still unclear to many people. The Group was seen as having a weak connection with its grass roots.

##### *Community Voices and Speakers Bureau*

Presentations from people with experience of mental illness are variously referred to as Community Voices, Speakers Bureau, Like Minds Workshops, Debunking the Myths workshops, and speaking engagements (although Community Voices is technically a training resource rather than a form of presentation). Milburn identified these presentations as valuable and in demand. The southern report also noted that while international literature (and especially Sayce) identifies the importance of people with experience of mental illness speaking out about discrimination, the research does not necessarily support the ‘telling of stories’. BRC reported concerns with such activities, noting that there does not appear to be any explicit theoretical basis for presentations where consumers disclose their mental illness, and that there is limited evidence of their

value in meeting the project objectives. It was also noted that the quality of speakers varies widely, and that safety issues are not always well addressed for some presenters.

### ***Māori participation***

Māori providers were well represented in the evaluation process. For Māori, the key to success will be adapting aspects of the project to meet their cultural requirements. While many Māori providers have performed very well, there have been problems with roles, responsibilities and accountabilities. The lack of a Speakers Bureau for Māori was suggested as a gap in delivery, but BRC recommended that the value and appropriateness of a Māori Speakers Bureau be reviewed, because the development of collective activities with groups of consumers may be as successful as individual activities in empowering consumers. Further, group activities may encourage a greater level of participation without placing consumers at risk. Māori community education objectives need to be strengthened, to ensure they are focused on effectiveness in meeting the project goals. Māori providers also need to deal with many of the same issues that face all providers in the project.

### ***Pacific peoples' participation***

The success of the project for Pacific peoples lies in the development of an approach that is effective and culturally appropriate. In the northern and central evaluations, Pacific providers were noted to have struggled to reach their communities, given the large number of separate ethnic communities and languages involved. (There are no contracted Pacific providers in the midland region.) Pacific providers also had difficulty accessing community resources on behalf of audiences for whom English is a second language or a language they are not conversant in. BRC noted that the Pacific provider in the central region appears to have accessed their community well, even though their resources are stretched. In the southern region, public health held an umbrella contract for a group to get it started.

As with Māori, Pacific community education goals need to be clarified. One recommendation for Pacific providers is to work with mainstream government and mental health service organisations that have a high proportion of Pacific people as their clientele.

### ***Capacity building and skill development***

While everyone recognises that, in theory, capacity building is essential for the project, the mechanisms for achieving it and capacity building itself are not so well practised. Quality people produce quality results, but quality people need professional development. Turnover affects productivity, and provider capacity issues can hinder the project's performance. Phoenix recommended that staff receive professional development and mentoring from outside their own organisations where this is needed. BRC recommended that the Ministry of Health communicate its expectations to providers about training and other capacity building to best use Like Minds resources.

### **3. Project activities**

#### ***Workshops and facilitation***

All the evaluations discussed aspects of community education and awareness raising workshops, and all had reservations about issues of quality, focus and effectiveness. Developing facilitation teams is an important process, but also a slow one if networks are to be strengthened: it takes time to build trusting relationships. There needs to be a greater focus on providing follow-up to support workshops. Workshops for people with experience of mental illness should be considered appropriate if the focus is on empowering them to deal with stigma and discrimination in their own lives.

While there are indications of good impacts from many workshops, there is a need to review the focus, to ascertain or ensure the effectiveness of these activities. Consumer safety is also an issue. The uncertainty about their effectiveness needs to be considered in relation to the personal risk for consumers (eg, where workshop formats include the disclosure of the speaker's mental illness) according to BRC. Milburn also noted that the theoretical base supports the inclusion of people with experience of mental illness, but it does not necessarily endorse people speaking of their personal experience of mental illness.

Resources for community education workshops are not always allocated according to skills: there can be tension between having presenters who are genuine and deeply sincere, and having presenters who have more skills in taking workshops. Training does not automatically turn anyone into a good presenter.

The tertiary training sector – and especially journalism students and those who will work directly with people with experience of mental illness, such as community support workers, mental health nurses and psychiatric registrars – should be considered an appropriate target for education about stigma and discrimination associated with mental illness. Note that this education would benefit from greatly increased attention to the actions people can take, and the things people can take do to reduce discrimination in their work.

#### ***Hearing Voices***

There is disagreement about the value of Hearing Voices workshops. The southern report questioned whether Hearing Voices workshops should be used at all, citing concerns that the workshops may increase discrimination. BRC recommended that the project seek to develop a culturally appropriate New Zealand version, because providers gave this a high priority, and because Māori and Pacific teams would use such a resource if it had more of a New Zealand flavour.

## ***Communication***

Project newsletters were identified as very helpful for keeping people in touch with what is happening. Participation in the national provider hui was also seen as valuable. Phoenix reported that people with experience of mental illness would like to receive more information about the project, and that they found personal contact important for communication. Huia Communication's work in co-ordinating print resources, media and as a communication channel between providers was widely acknowledged as an important contribution.

## ***Media reporting***

Stigmatising reporting in the mass media continues to be a major problem, and poses a major challenge to the project. The Milburn and BRC evaluations recommended that the national level of the project promote media responses where negative or stigmatising coverage occurs.

## ***Resource development***

Two evaluations discussed the development of project resources. BRC recommended that Pacific Islands languages resources be developed for the project. Phoenix reported mixed results from resource development: one video had a high-profile launch, while another video venture that was funded did not result in a final product. Phoenix recommended that any further resources be developed nationally, rather than by individual providers.

## ***Other activities***

### ***Respect awards***

These were seen as a positive initiative.

### ***Mental Health Awareness Week (MHAW)***

MHAW was seen as being of questionable value for the project's goals in two regions. Phoenix recommended that providers, especially those in Auckland, place less emphasis on MHAW because of the difficulties identified by providers in connecting the general mental health promotion themes of MHAW with the project goals of reducing stigma and discrimination against those who already have experience of mental illness. Northern and midland providers found that MHAW was resource intensive, but did not necessarily link to other parts of their work. BRC reported that six of the ten providers/teams used the week to run some fairly extensive and probably quite effective activities.

### ***Drama productions***

The northern and midland evaluations questioned the value of drama productions, and recommended that they should not be a high priority. BRC noted that Pacific and Māori teams, in particular, appeared to value group communication in the form of drama pieces, waiata, etc, and that these teams report that drama is an effective mode of delivery for them.

## **4. Specific targets**

### ***Mental health services***

The central and southern evaluations identified a lack of progress with mental health services, including non-government organisations (NGOs) that provide mental health services. BRC identified reaching and working with these services as a major gap in that region's contribution to delivering on the National Plan. Milburn noted that there is potential – and the need – for an effective strategy with mental health services. Phoenix reported that their mental health services research indicated that staff were very positive about the project, that they could be developed as key allies and champions for the project, and that more workshops and seminars should be delivered to this sector.

Milburn surveyed staff in mental health services to identify their awareness of the campaign, and found that public health workers had the highest levels of awareness, and that the lowest levels were among nurses and clinicians. Both Milburn and Phoenix recommended that project participants seek to develop long-term relationships, embedded in policy and practice. This includes the business planning of mental health services, especially in District Health Boards.

Phoenix recommended that newsletters to mental health service providers be sent in sufficient numbers for copies to reach different parts of the services.

### ***Focus on actions staff can take***

Phoenix and Milburn both recommended that training have a greater focus on actions that staff and the organisation can take to reduce stigma and discrimination. Phoenix pointed out that people often don't know how they discriminate, so telling them not to won't be very effective. Milburn pointed out that workforce trainers indicated they would welcome guidance on how to be non-discriminatory, and on how to teach this. Providers also need to identify the most effective targets within District Health Boards: internal trainers or clinical managers. In working with Boards, the project also needs to be honest and respectful of power issues and to create space for debate and the clarification of roles.

Like Minds providers need to maintain institutional knowledge, so that people are not regularly starting from scratch with mental health service providers (which can be frustrating for the services).

### ***Primary health services***

While primary health services are not yet a priority group, they are increasingly significant for people with experience of mental illness. The project needs to develop a strategy to gain work with local primary health services.

### **Government agencies**

The government agency project evaluation (Milburn) recommended the need for models of policy work to be developed and/or made explicit, and emphasised the need for national co-ordination of government agency work. The report also stressed the importance of working at policy level with key government agencies, alongside training for frontline staff. Consumer-led anti-discrimination training was highly rated by Police, Housing New Zealand and Child Youth and Family Services of the Ministry for Social Development.

People with experience of mental illness reported that they have perceived at least some positive change in government departments. However, the regional evaluations noted clearly that the project needs to make more progress in this area. Some providers had success in getting to the Department of Work and Income and the Police, but these were mostly for one-off or ad hoc sessions, and ongoing demand was not apparent.

Phoenix recommended that where an agency assigns particular staff to work with people with experience of mental illness, those staff should be the first targets within those organisations. BRC noted that getting to 'hard to reach' audiences, such as police and social services, can take up a considerable proportion of local resources for only limited impact, and that ideally this should be a national role. Phoenix believes these groups need to be a priority because of the impact they have on the lives of consumers.

The government agency project evaluation (Milburn) noted that although the sub-project was slow to get under way, by the end of the evaluation period there was for the first time in the Like Minds project an integrated approach between mainstream regional and national actions and an effective two-way communication system. However, those able to sustain this were larger providers (including Regional Public Health and the Mental Health Foundation), whereas small providers who had been initially involved (including Māori and Pacific providers) were lost along the way. Limited resources and pressing service provision priorities were possibly part of the reason for this. The evaluation identified a need – which had seemed desirable at the outset – to address the barriers to participation.

One Māori provider reported an ongoing negative relationship with the police and the way they treat local consumers. The Like Minds team feel that it is inappropriate for them to target police as an audience while this situation remains, because it would be too unsafe for the consumers involved.

All regional evaluations identified issues about alignment between the regional and national policy projects, and recommended closer connection between the two components. Regions can also assist by gathering information on issues to feed into national policy and advocacy.

## ***Other audiences and communities of interest***

### ***Families and whānau***

Families and whānau should be seen as appropriate targets for anti-discrimination workshops, and this was seen as especially relevant for Pacific communities.

### ***Children / youth***

These are a low priority, and targeting of children and school-aged youth should be a low priority, within kura and other primary schools. The Phoenix regional evaluation noted that the international research literature does not support school-based education as a particularly effective means of health promotion, especially if it is one or a few sessions in isolation.

### ***General public***

The general public should not be a target priority group, because the limited provider resources cannot begin to make an impact on this large and diverse group. This activity is best left to the mass media advertising.

## **5. Funder activities**

### ***Mass media campaign – saving the best for last***

The television advertising campaign has been successful in having an impact, according to 80 percent of people with experience of mental illness surveyed by Phoenix. Many people with experience of mental illness reported reduced stigma and discrimination, although Phoenix's 'key informants' were not so sure. The ads are seen to be appealing, and there is strong overall support for the campaign. Phoenix has recommended that any future campaigns use everyday people, and work on acceptance of schizophrenia and other (less acceptable) mental illnesses.

### ***Management and co-ordination***

#### ***National Plan***

The Like Minds National Plan 2001–03 brought a sense of connection to providers, who could then see that they were all engaged on the same project. However, some providers would benefit from having the strategic objectives explained to them, together with advice on how to operationalise the plan. BRC also recommended that the Ministry confirm that it does not expect *all* providers to work on *all* objectives.

### *Models and best practice*

Given that providers use a variety of models and approaches, and given that there are some concerns about the safety, quality and effectiveness of some of the approaches that underpin providers' work, BRC recommended that the Ministry develop theoretical models for core project activities (such as activities that involve consumers disclosing their mental illness) and educate providers about these. In addition, providers want information about international best practices, and the Ministry could enable this, and monitor progress towards achieving it.

Milburn's evaluations for the South Island and for the government agency project both referred to the perceived lack of collaboration among Ministry of Health purchasers, and the need for a more consistent approach, particularly for government agency policy work and media strategies.

### *Purchasing*

The central region evaluation recommended that the Ministry continue to purchase from the current providers, because they are making progress and have established relationships with local people with experience of mental illness. They also recommended that the Ministry consider contracting a consumer group to do any future evaluations of the project.

Some providers feel obliged to include activities under each National Plan objective, because their contract would appear to require this, despite the lower level of resourcing smaller providers receive. If the funder clarified its requirements in this area, smaller providers especially would be better able to focus on those activities that are likely to be effective and relevant for their area.

### *Facilitate development of models by Māori and Pacific providers*

BRC recommended that the Ministry expand its facilitation of culturally appropriate delivery of the project by Māori and Pacific providers/teams, because this is a contractual requirement of service delivery of Māori teams, as well as an objective of the National Plan.

## **Appendix 3: Consistency with national health strategies**

### **New Zealand health strategy**

The New Zealand Health Strategy contains explicit reference to the recognition of the human rights of people within the health care system, stating that individuals have fundamental rights within a quality health care system. They include rights under the Privacy Act 1993 and those recognised in legislation through the Health and Disability Commissioner Act 1994. The latter Act covers:

- the right to be treated with respect
- the right to freedom from discrimination, coercion, harassment and sexual exploitation
- the right to dignity and independence.

### **Public health strategy**

Public health is about improving the health of populations. Public health takes a population health approach:

- taking into account all factors which determine health
- planning how these factors can be tackled.

Public health action can:

- take place at many levels throughout the health sector and beyond
- be planned and implemented in collaboration with other sectors
- advise other sectors on the health impact of their activities, and where necessary, regulate these
- supports other parts of the health sector to take a population health approach to service planning and delivery.

To achieve this, all sectors – including education, justice, employment, transport, police and local government – work together with their communities to address the wider determinants of health. Public health strategies are planned using a mix of actions related to the Treaty of Waitangi and the five components of the Ottawa Charter framework.

### **Mental health strategy**

The National Mental Health Strategy has two key goals:

- To decrease the prevalence of mental illness and mental health problems within the community
- To increase the health status and reduce the impact of mental disorders on consumers, their families, caregivers and the general community.

## **New Zealand disability strategy**

The New Zealand Disability Strategy presents a vision of a society that values disabled people's lives and continually enhances their full participation in society. The Strategy acknowledges that disability is not something that people have, but that disability is the process that happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have.

The New Zealand Disability Strategy identifies 15 objectives, underpinned by detailed actions, to advance New Zealand towards being a fully inclusive society. These are to:

- encourage and educate for a non-disabling society
- ensure rights for disabled people
- provide the best education for disabled people
- provide opportunities in employment and economic development for disabled people
- foster leadership by disabled people
- foster an aware and responsive public service
- create long-term support systems centred on the individual
- support quality living in the community for disabled people
- support lifestyle choices, recreation and culture for disabled people
- collect and use relevant information about disabled people and disability issues
- promote participation of disabled Māori
- promote participation of disabled Pacific people
- enable disabled children and youth to lead full and active lives
- promote participation of disabled women in order to improve their quality of life
- value families, whānau and people providing ongoing support.

Departments and ministries across the government sector are developing implementation plans for the New Zealand Disability Strategy. This planning will become part of the annual cycle for departments, and progress must be reported annually to the public and to the House of Representatives by the Minister for Disability Issues.

## **Mental health promotion**

*Building on Strengths* establishes a platform for continued improvements in mental health and wellbeing for all New Zealanders over the next five years, and outlines the way in which mental health promotion can contribute to a wide range of sectoral health-promoting agendas and policy priorities. The framework identifies key directions and opportunities, including, goals and action streams that the health sector can support to achieve improved mental health outcomes.

*Building on Strengths* further seeks to promote health and contribute to a reduction in inequalities by enhancing the mental health and wellbeing of people who are affected by their socioeconomic status, or who are vulnerable as a result of their social isolation. It builds on the good work already being done throughout the country at local, regional and national levels.

Of particular relevance to the Like Minds project to reduce discrimination are the priority actions outlined by the strategy document that focus on:

- building community cohesiveness through activities that make them safer
- reducing structural barriers to mental health through partnerships to improve access to conditions that promote positive mental health, such as education, meaningful employment and suitable housing.

### **Inequalities in health**

The Inequalities Strategy seeks to reduce inequalities for all New Zealanders. The impact of many complex factors leading to poor health status is particularly evident among Māori and Pacific peoples and has resulted in disparities in Māori and Pacific peoples' health status. The most effective means to reduce disparities will focus on:

- intersectoral approaches
- building on existing initiatives.

Often other sectors are responsible for leading work at these levels (eg, in housing and employment), so it is important for health policy-makers, funders and service providers to develop appropriate intersectoral linkages (in line with the Ottawa Charter).

### **Youth health strategy**

The Ministry of Health and Ministry of Youth Affairs are developing a comprehensive Youth Health Strategy for the Government, because although the health of young people is better than that of most other age groups, there are significant areas of concern, including the rates of suicide and attempted suicides. An increase in their health status is vital to assist in reducing inequalities. The strategy will focus on:

- further development of intersectoral work to reduce the rate of youth suicides and suicide attempts
- developing mental health programmes that focus on wellness
- improving the range of accessible and appropriate services for youth (eg, one-stop shops and Youth Health Centres)
- increasing the range and number of Māori services for youth
- increasing the range and number of Pacific peoples' services for youth
- encouraging greater co-ordination between different health care providers working with youth, and between health sector providers and other agencies whose services affect the health of youth.

## **Appendix 4: Ottawa Charter for Health Promotion**

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The five components of the Ottawa Charter framework are:

### **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 socio-ecological 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.

## **Appendix 5: Project providers at July 2003**

### **Kaitaia**

Te Hauora o te Hiku o te Ika, 49 Redan Rd, Kaitaia  
Tel (09) 408 4024, mereana@hauora.net.nz

### **Whangarei**

Northland Health, PO Box 742, Whangarei  
Tel (09) 430 4101, joyr@nrh.co.nz

### **Auckland**

Framework Trust, PO Box 52-164, Auckland  
Tel (09) 8155 123, Fax (09) 8155 149, likeminds@framework.org.nz

Hapai te Hauora Tapui, PO Box 26-593, Epsom, Auckland  
Tel (09) 520 4796, Fax (09) 520 4797, hauora@hapai.co.nz

Mental Health Foundation, PO Box 10-051, Dominion Rd, Auckland  
Tel (09) 300 7010, Fax (09) 300 1020, shae@mentalhealth.org.nz

Pacificare, PO Box 23-240, Papatoetoe, Auckland  
Tel (09) 279 8030, Fax (09) 279 8047, leacowley@ezysurf.co.nz.

### **Hamilton**

New Progress Enterprises (NPE), PO Box 1367, Hamilton  
Tel (07) 838 0302, Fax (07) 838 0507, uia@npe.co.nz

Raukura Hauora o Tainui, PO Box 5158, Frankton, Hamilton  
Tel (07) 846 1389, Fax (07) 847 3829, wikig@rauakura.com

### **Bay of Plenty**

Serious Fun’N Mind Trust, PO Box 592, Whakatane  
Tel (07) 308 0304, Fax (07) 308 0306, SeriousFunNMind@xtra.co.nz

Poutiri Trust, PO Box 148, Te Puke  
Tel (07) 573 6413, Fax (07) 573 6316, poutiri@wave.co.nz

### **Gisborne**

Turanga Health, PO Box 41, Gisborne  
Tel (06) 869 0762, Fax (06) 867 8958, marg@turangahealth.co.nz

## **Hawke's Bay**

The Lighthouse, 25 Clive Square West, Napier  
Tel (06) 835 1604, Fax (06) 835 1603, onelight@xtra.co.nz

Taiwhenua o Heretaunga, PO Box 718, 204 Portsmouth Rd, Flaxmere, Hastings  
Tel (06) 879 5276, Fax (06)-876 5820, hauora@ttoh.iwi.nz

## **Taranaki**

Like Minds Taranaki, PO Box 767, 13–15 Devon St West, New Plymouth  
Tel (06) 759 0966, Fax (06) 757 8789, mental.health@clear.net.nz

Toiora – Health Lifestyles Ltd, 229 Devon St West, New Plymouth  
Tel (06) 769 9188, donna.leatherby@xtra.co.nz

## **Whanganui**

Public Health Unit, Good Health Whanganui, PO Box 645, Wanganui  
Tel (06) 348 1234, Fax (06) 345 8776, nicolaw@ghw.co.nz

Te Whakapiki te Mohiotanga Te Oranganui Trust, PO Box 611, Wanganui  
Tel (06) 345 6882, (06) 345 6168, marus@teoranganui.co.nz

## **Palmerston North**

Public Health Unit, MidCentral Health, PO Box 2056, Palmerston North  
Tel (06) 350 8469, Fax (06) 350 9111, paulineb@midcentral.co.nz

## **Wellington**

Public Health Unit, Hutt Valley Health, Private Bag 31-907, Lower Hutt  
Tel (04) 570 0044, Fax (04) 570 4405, jillian.barclay@hvh.co.nz

Pacific Community Health, PO Box 53-018, Porirua  
Tel (04) 237 7751, Fax (04) 237 7783

Te Roopu Pokai Taniwhaniwha, PO Box 50-577, Cannons Creek, Porirua  
Tel (04) 237 9350, Fax (04) 238 9350, trpt@clear.net.nz

## **Nelson**

Public Health Unit, Nelson Marlborough Health, PO Box 647, Nelson  
Tel (03) 546 1549, Fax (03) 546 1542, gaye.berry@nmhs.govt.nz

Te Rapuora o te Waiharakeke, c/- Whakatu Marae, 64 Nile St, Nelson  
Tel (03) 546 9997, bob.tamihana@tewaiha.org.nz

## **Blenheim**

Public Health Unit, Nelson Marlborough Health, PO Box 46, Blenheim  
Tel (03) 577 1914, Fax (03) 578 9517, [evin.wood@nmhs.govt.nz](mailto:evin.wood@nmhs.govt.nz)

Te Rapuora o te Waiharakeke, PO Box 220, Blenheim  
Tel (03) 578 3348, Fax (03) 578 8034, [1128@clear.net.nz](mailto:1128@clear.net.nz)

## **Christchurch**

Mental Health Foundation, PO Box 13 167, Armagh St, Christchurch  
Tel (03) 366 6936, Fax (03) 365 5879, [frances@mentalhealth.org.nz](mailto:frances@mentalhealth.org.nz)

Te Awa o Te Ora, PO Box 13-167, Armagh St, Christchurch  
Tel (03) 379 2053, Fax (03) 365 5345, [teawatrust@paradise.net.nz](mailto:teawatrust@paradise.net.nz)

Hibiscus Health, PO Box 1475, Christchurch  
Tel (03) 379 9480, Fax (03)- 79 6125, [edith.ieremia@cph.co.nz](mailto:edith.ieremia@cph.co.nz)

Christchurch District Advisory Group, c/- Like Minds Canterbury, Crown Public Health,  
PO Box 1475, Christchurch  
Tel (03) 379 9480, [Maria.Pasene@cph.co.nz](mailto:Maria.Pasene@cph.co.nz)

## **West Coast**

West Coast District Advisory Group, c/- Crown Public Health, 3 Tarapuhi St, Greymouth  
Tel (03) 768 4290, Fax (03) 768 4605

## **South Canterbury**

South Canterbury District Advisory Group, PO Box 612, 29 King St, Timaru  
Tel (03) 684 8929, Fax (03) 688 0000, [tmhst@xtra.co.nz](mailto:tmhst@xtra.co.nz)

Waitaki Community Mental Health Service, PO Box 94, Oamaru

## **Otago**

Like Minds Otago, PO Box 5829, Dunedin  
Tel (03) 471 8082, [lmotago@ihug.co.nz](mailto:lmotago@ihug.co.nz)

Otago District Advisory Group, c/- Public Health South, 57 Hanover St, Dunedin  
Tel (03) 474 1700, [richard.egan@phsouth.co.nz](mailto:richard.egan@phsouth.co.nz)

## **Southland**

Public Health South, PO Box 1601, 92 Spey St, Invercargill  
Tel (03) 211 0900, Fax (03) 211 0899, [karen.goffe@phsouth.co.nz](mailto:karen.goffe@phsouth.co.nz)

**National**

Huia Communications, PO Box 17-335, Wellington  
Tel (04) 473 9262, Fax (04) 494 1838, [likeminds@huia.co.nz](mailto:likeminds@huia.co.nz)

Mental Health Foundation of New Zealand, PO Box 6563, Marion Square, Wellington  
Tel (04) 801 0352, [gael@mentalhealth.org.nz](mailto:gael@mentalhealth.org.nz)

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