Social inclusion, for many reasons, is recognised as a vital component of recovery for people with experience of mental illness.

Social inclusion is about being part of a community and its strong ties and communication. It’s about belonging to a network of supportive relationships that are protective of good health and positive wellbeing.

One definition of a socially inclusive society is where “all people feel valued, their differences are respected and their basic needs are met so that they can live in dignity”.

Another describes social inclusion as “being able to rejoin or participate in leisure, friendship and work communities. Inclusive communities provide equal opportunities for sharing power and resources amongst different people in society. Individuals not only meet their own needs but reach out to meet the needs of others.”

For Aaron Woolley, Waikato Regional Like Minds, Like Mine Service Co-ordinator, Te Korowai Hauora O Hauraki, “Social inclusion is a society where all people are included to the best of their abilities and supported to the extent of their needs in an independent lifestyle.”

Continued on back cover
From Psychiatric Patient to Citizen: putting mental health at the heart of equality and human rights

For years internationally, mental health policy and practice has been separated from other policy developments through separate mental health legislation, separate policies and separate services.

Liz Sayce, Chief Executive of RADAR in Britain, is committed to making lives better for those people with experience of mental illness.

“I believe that mental health needs to be placed at the centre of mainstream policy development and delivery.”

Liz says that one of the keys to achieving change in Britain is getting mental health needs noticed by politicians.

“We knew that British MPs were interested in child poverty, so we told them about the statistics that linked mental ill health to child poverty,” says Liz.

The statistics revealed that a third of children living in poverty had at least one disabled parent – and that the group with least success in moving out of poverty were parents whose disability was a mental health condition.

“Talking about it in this way changed the debate on mental health problems and poverty from being a ghettoized mental health issue – of interest only to the mental health community – to a wider issue of child poverty and social justice,” says Liz.

Similarly, Liz says that the British Government will not be able to reach its own general goals of improving skills, employment and affordable housing unless it plans for those most excluded: disabled people, particularly those with mental health problems.

“Systemic discrimination can lead to reduced life expectancy and quality of life,” says Liz. “If we can successfully challenge this discrimination where ever we find it, then we engage with social inclusion on many levels.”

Liz says that this thinking is reflected in much of New Zealand’s Like Minds, Like Mine campaign.

“New Zealand is a world leader in anti-discrimination work and a leading voice in the United Nations Convention on the Rights of People with Disabilities,” she says.

“Your Like Minds, Like Mine campaign works to establish principles of equitable contact between people, connection on mutually agreeable terms, shared goals and the opportunity to refute stereotypes.

“In Britain, the organisation Rethink ran a campaign in Norwich, drawing on the themes of celebrating difference, celebrating humanity and challenging preconceptions.”

Rethink Norwich anti-discrimination pilot

Rethink aimed to change people’s beliefs about mental illness by challenging their current views and opinions and reducing the social distance between those with experience of mental illness and those without. The campaign utilised a combination of advertising on buses and radio, a media engagement programme, member, supporter and staff participation, a GP engagement programme, door drops, face-to-face fundraising and followed up the campaign with comprehensive evaluation.

Did it work?

The campaign addressed ideas about mental illness and dangerousness, with a high success-rate and raised issues about people with experience of mental illness in important jobs.

• Before the campaign, 15 per cent of people were prepared to say that they had experienced mental health problems. After the campaign, 30 per cent.

• Before the campaign, 33 per cent of people thought that people with experience of mental illness are often dangerous. After the campaign it dropped to 21 per cent.

• Before the campaign, 24 per cent of people thought that people with experience of mental illness should not be allowed to do important jobs. After the campaign it dropped to 14 per cent.

• Before the campaign, 40 per cent of people said that they would not want to tell someone if they developed a mental illness. After the campaign, it dropped to 22 per cent.

In general people said that they found it easier to talk about mental health and would be more comfortable talking about their own experiences now and in the future. Overall, people’s fears of “dangerousness” were down and their awareness of Rethink went up.

What next?

Liz sees the future of mental health equality as a series of steps – educate, educate then litigate.

“In Britain there has been a number of high profile examples where anti-discrimination law has been used by individuals with mental health problems to achieve redress,” she says.

“We have found that individual cases are useful to highlight issues in the media and to employers; but they do not always change whole systems.”
Who is Liz Sayce?

Liz Sayce was a special guest presenter at the Enhancing Our Com(m)onunity conference in Rotorua in April.

Liz is the Chief Executive of RADAR, the UK’s leading disability network. She has also worked as the Director of Policy and Communications, Disability Rights Commission (UK), the Director of Lambeth, Southwark and Lewisham Health Action Zone and has spent eight years as Policy Director of Mind.

Liz has published widely on mental health and disability issues including articles and chapters on mental health and social exclusion and effective approaches to tackling discrimination. She is well known for her book ‘From Psychiatric Patient to Citizen’ (overcoming discrimination and social exclusion), 2000.

RADAR web: www.radar.org.uk/radarwebsite/
“Recovery from mental illness relies on resilience, confidence, self-esteem, having a sense of purpose, having close and confiding relationships and hope for the future” says Gregor Henderson, Director of Scotland’s National Programme for Improving Mental Health and Wellbeing (www.wellscotland.info).

The work of the national programme includes work on promoting mental wellbeing, eliminating stigma, supporting recovery, social inclusion and improving mental health literacy.

“What we are discovering through the work of the national programme is that thinking, feeling and relating to ourselves and others is essential to our personal, family, neighbourhood, and community mental health and wellbeing,” says Gregor.

“When people feel socially connected they have more positive feelings of self worth, are more effective, and live more engaged and fulfilled lives.”

The results and benefits from the work in Scotland borrow from the mental health recovery movement and show that:

- People’s wellbeing is enhanced by their process of recovery and vice versa.
- Improved mental wellbeing adds productive-and-quality-of-life-years to the community and to individuals.
- High quality local prevention care and treatment services, for people with mental health problems and the wider community, makes for a more resilient and socially well society.
- Positive mental health for all goes beyond traditional mental health care policy. The language of mental health and mental wellbeing is taken beyond the care and treatment sector into community development and into wider policy areas such as inclusion, equalities, employment, education and community regeneration.

Gregor says, “The realisation is – social inclusion and wellbeing are the keys to more sustainable and emotionally healthy communities. It really does matter how communities feel and relate.”

“Leadership and self-determination are also key factors, allowing communities and marginalised groups to lead themselves, to decide for themselves what is good for them, and work towards those ideals.

“Much of what we have learned about addressing stigma, for example, comes from looking to New Zealand’s Like Minds Like Mine campaign,” he says.

“In New Zealand you ‘walk the talk’ on consumer leadership and seek service-user leadership in your work. You are a source of inspiration for us.”

Scotland’s work highlights the connection between mental health, healthy communities and wellbeing and is one reason why governments in Scotland and the UK are beginning to give more prominence to wellbeing as an important social and policy goal. In Scotland they now have a Government Directorate of Health and Wellbeing replacing the older-style Health Ministry Department. Scotland even has a government-funded Centre for Confidence and Wellbeing.

“These initiatives and programmes, including our one on mental wellbeing, are investments in achieving desirable social goals which have benefits and pay offs for countries in terms of improved quality of life, reduced needs for special education, reductions in criminal behaviour and improved physical and mental health” says Gregor.

There are universal approaches to wellbeing that draw on mental health recovery approaches which all help to make for a healthy society. There are also grass-roots solutions to social problems.

This is social development as well as health development and improvement. One important part of this approach is research and evaluation. We need to know what works and what looks promising to help extend the evidence.

What’s more, evaluations need to be based on what communities decide is good for the community. This draws on mental health knowledge where evaluation is based on what service users say are the important outcomes, and lead improvements in services based on these outcomes.

In the end, what promotes recovery from mental illness is the same as what promotes healthy communities and good mental wellbeing. So, social inclusion for people with experience of mental illness needs to be part of the wider agenda of social development and wellbeing for our communities.

Gregor Henderson presented the work of the National Programme at the recent Enhancing Our Com(mon)unity conference in Rotorua.

The ‘see me’ national anti-stigma campaign

The ‘see me’ campaign is Scotland’s equivalent to Like Minds. It was launched in October 2002 to challenge stigma and discrimination around mental ill health in Scotland. The campaign is run by an alliance of five Scottish mental health organisations and combines an award-winning national publicity programme with local and national anti-stigma action developed in partnership with like-minded groups and individuals across all sectors of Scottish life. ‘see me’ is fully funded by the Scottish Government’s National Programme for Improving Mental Health and Wellbeing.

For more information on ‘see me’ go to http://www.seemescotland.org.uk/

For the National Programme go to http://www.wellscotland.info
This scene from The Singing Detective helped introduce WALSH Trust Director, Rob Warriner’s discussion on mental health services and social inclusion at the recent Enhancing Our Com(mon)unity conference. The scene clearly illustrates:

- How much things have changed. It exaggerates and provides a caricature of the many traits and attitudes that were prevalent in health, not so long ago.
- The classical doctor/patient roles with its professional and physical distance. (Although it was momentarily challenged, the status quo was restored amid apologies – from the patient – for any “inappropriate” behaviour.)
- That discomforting sense of familiarity and recognition. Many things have certainly changed, but a few things are hanging on.

In 2007, we are clearly moving away from services that are self-serving and about their own needs, rather than service users’ needs. However challenges remain.

In 2004, a report was published by the British Social Exclusion Unit – Mental Health and Social Exclusion – in which it concluded, that “adults with long term mental health problems are one of the most excluded groups in society.”

It advised that the role and purpose of mental health services needed to be revised with a focus on preventing people losing their jobs, their relationships and their place in society.

“But how successfully have mental health services responded to this challenge?” asks Rob Warriner.

“For WALSH Trust,” he says, “It is just this challenge that has led development over the last three years.”

New Zealand’s WALSH Trust services are increasingly about relationships – the basic building blocks of a socially included life. WALSH sees their core business as recovery and social inclusion and aims to do more than just pay lip service to their beliefs.

“People do not recover in isolation,” says Rob. “People are social beings and whereas in the past people were removed from the community and ‘treated’ – services like WALSH prefer to support people in their own communities, helping them develop and maintain relationships with others.”

WALSH Trust has the expectation of that ‘community connection’ written into the job descriptions of every member of staff.

“WALSH embraces social inclusion and aims to respond to what service users want. A very clear focus is to offer services to people in their communities, not ours. We try to focus far more on social determinants of health. A reality is that ‘mental health’ is a social phenomenon; it happens in the community, not within a service,” says Rob.

This has meant services such as supported employment have emerged to be more of a core service rather than an add-on.

“Providing employment services for people who experience mental illness provides continuous challenges – and this is how it should be. The demands of developing relationships and partnering with employers has illustrated how socially excluded mental health services themselves can be,” Rob says.

“Employment’s role in social inclusion can not be underestimated.”

Once a provider of old-style workshops and in-house programmes, WALSH has closed these down and replaced them with a focus on community integration and participation.

“Building social inclusion into the organisation was essential,” says Rob. “And WALSH has done this by bringing supported employment into the open, rather than hiding it away.” They now have six full-time employees providing supported employment services.

WALSH’s approach is in line with the solutions proposed in the Mental Health and Social Exclusion report, which highlighted the necessity for mental health services to recognise people needed more than just a medical response. They needed employment, a home, positive and caring relationships with their families and their communities, participation in social activities and adequate health care.

Social integration is a key objective of New Zealand’s National Mental Health plan and if successful will lead to a change in service delivery culture.

So, let’s get serious – it’s all about inclusion!
More than 40 trainers were welcomed to Wellington’s Mercure Hotel in Willis Street on 12–13 June 2007 to attend the second annual Like Minds, Like Mine Training and Education Hui. Key presentations included:

**Hine Martin, National Maori Development Manager at Te Pou**

**Facilitation skills**

For Hine Martin it was important to ensure Hui participants understood the importance of telling the stories that matter, engaging with human emotions and making the best use of academic discourse.

Hine says, “Upholding the integrity and mana of the people (Kia mau te mana tangata) valuing our authenticity (aroha ki te tangata) is paramount.”

“In pitching a workshop you need to consider your audience – where are they in the process of changing their behaviour?” The cycle runs from belief to knowledge to attitudes to behaviour.

**Darryl Bishop, Programme Leader, Like Minds, Like Mine**

**Key areas of focus for the Like Minds National Project**

Darryl spoke about key areas of focus for the National Project including the National Plan, phase four advertising, and where we are today in education and training (see page eight for more information).

**Tikanga Perspective, Maori Caucus**

As part of a group discussion about the National Project Lila Baker and Marius Joseph from the Maori Caucus gave a Tikanga perspective on the National Plan, presenting the diagram of a whale, called Rangiatea, which they have developed to explain the key aspects of the plan. The diagram and accompanying explanations were currently being looked at by a Kaumatua and undergoing a proper consultation process before being included in the Like Minds National Plan.

**Sarah O’Connor, Case Consulting**

**National Evaluation System for education and training providers**

There were 1,601 more participants in Like Minds training in the year ending June 2007 compared to the year ending June 2006. The data showed that not only had participant numbers almost doubled, but also the number of sessions had increased by 48 per cent even though there were only two more providers (from 12 to 14).

2007 participants most valued the presentations about personal experience (36.5 per cent), followed by group discussions (13.5 per cent) and information provision (11.5 per cent).

Providers not yet using the evaluation system who would like to contribute can email saraho@caseconsulting.co.nz.

**Dean Manly, Case Consulting; Darryl Bishop, Like Minds National Programme Leader; Sokopeti Sina, Vakaola; Deb Christensen, Manager of the Northern Regional Consumer Network**

**Panel discussion on internalised stigma**

Internalised stigma was described as ‘insidious’ and an issue worthy of further research. Like Minds trainers spoke about their reluctance to disclose their own mental health experiences because of internalised stigma – but how much more effective their training was once they had overcome that stigma and could be open about their experiences.

In addition, participants gave group presentations to share solutions on topics such as debriefing, working in groups, dealing with difficult people in workshops and incorporating different styles.

After two days of intense discussion, participants flew back to their own corners of the country, re-energised and with new skills to use in their work to reduce stigma and discrimination associated with mental illness.

A special thanks to entertainers Black Snapper (a Napier band fronted by Roy Brown, General Manager of the Lighthouse Trust) – keep those rockabilly tunes coming!
Promoting social inclusion through open employment

“Out of the blue your job has gone, with it any financial security you may have had. At a stroke, you have no purpose in life, and no contact with other people. You find yourself totally isolated from the rest of the world. No one telephones you. Much less writes. No one seems to care if you’re alive or dead.” (Bird, 1998)

“Employment is central to recovery for many people,” says Rachel Perkins, who was a keynote speaker at the recent Enhancing Our Com(mon)unity conference in Rotorua.

“To be part of a class of people that is considered unable and unfit to work is to be a member of a devalued and marginalised class,” she says.

“However, people with experience of mental illness who are employed are less likely to relapse and less likely to be hospitalised. In fact most want to work and the majority can – if they are given the right kind of help and support.”

Rachel believes work is a key component to regaining control over one’s life after the experience of mental illness. It links people to their community and helps them regain a sense of who they are beyond being a ‘patient’ and ‘beneficiary’.

“Work provides people with meaning and a purpose in life,” she says, “It provides social contacts and gives people the resources they need to do other things they value.”

Furthermore, employment allows the opportunity to refute stereotypes. It gives people an opportunity to get to know each other without diagnoses or disability, in a normal work environment, rather than isolated in a special workshop or scheme.

These elements are important to social inclusion, and have been missing in the past with the traditional services’ approach to isolation and exclusion. Rachel is the Director of Quality Assurance and User/Carer Experience at the South West London Mental Health NHS Trust. She’s been involved in the disability rights movement in the UK, and sees the future for service users as leading services rather than simply participating in them.

“Social inclusion means people with experience of mental illness running services for people with experience of mental illness,” says Rachel.

And where formerly mental health services were oriented towards fitting the person into the world as it is (if at all), the disability movement suggests that changing the world to remove obstacles for people makes for a better world.

For example: In London, an online service tailored to assist people using wheelchairs to plan a route without stairs around the city, was being used by people with lots of luggage, or with physical limitations such as heart problems. Accommodations for people with disability were useful to everyone.

This change in thinking prompted a revision of the South West London Mental Health NHS Services Strategy and Business Plan and some fundamental changes.

“We moved away from a primary aim of treatment and symptom reduction. Our primary purpose is now to help people do the things they want to do, live the lives they want to live and access those opportunities that all citizens should take for granted,” Rachel says.

“We focus on strengths and possibilities [rather than deficits and dysfunctions] and on fostering and promoting opportunity [rather than on providing care].”

The changes to the Trust also involved reviewing the skills and personnel they needed to promote recovery and facilitate inclusion.

“Every year since 1997, at least 15 per cent of all recruits to the organisation have had personal experience of mental illness,” says Rachel.

“In 2005/6 that increased to 17 per cent of all recruits having personal experience of mental illness.

“However, while 13 per cent of those in the lowest level positions had experienced mental illness, 23 per cent of those in the most senior professional and managerial positions had personal experience of mental illness – so although we cannot yet say that ‘the lunatics are running the asylum’, they are well on the way to doing so!”

The Trust’s employment services provide ‘Individual Placement with Support’, which is evidence-based, supported, employment. Employment Specialists are employed as part of community mental health teams and help people to gain and retain the jobs and education of their choice. In 2005/6, 687 people were supported to get/keep paid employment, 253 people were supported to study in mainstream education/training and 221 people were supported to do mainstream voluntary work.

“In the past, mental health services have been barriers to recovery, limiting people’s ability to access the life they want – one that is meaningful, satisfying and valuable – and their access to the same opportunities available to anyone else in the community,” says Rachel.

“The time has come for a service-user approach to removing these barriers and to raise the expectations of service users – dare to dream!”
Like Minds, Like Mine: From here to where?

Darryl Bishop, Programme Leader, Like Minds, Like Mine
speaks about the future direction of the programme

It has been 10 years since Like Minds, Like Mine was created following the 1996 Mason Inquiry.

In that time we have achieved and learnt a lot. We have 26 regional organisations focusing on local education, media, community action and community events and five organisations working at a national level focusing on research and policy, advertising and PR, a freephone service, advice, resources and training.

“...We are optimistic enough to believe that a well-informed New Zealand public will then realise that people with mental illness are people we should nurture and value.” (1996 Mason Inquiry)

Advertising campaign success

Since the start of Like Minds, Like Mine there have been three phases of media advertising, each one building on the other.

Phase one: Famous people with experience of mental illness
Phase two: “Are you prepared to judge”
Phase three: “Know me before you judge me”

Audiences have responded positively to all three phases so far and now that phase four has been launched we are expecting even more impetus (see page 9).

Speaking at the Enhancing Our Com(mon)unity conference, Darryl Bishop, Programme Leader, Like Minds, Like Mine says “The last ten years have proven to be a time of exponential growth for the Like Minds programme.

“One of the most important things we’ve learnt is that when you get momentum some things start happening by themselves, and this is a good sign!”

Darryl says that the success of the campaign relies on work at a number of different levels.

“The activities of our national and regional providers are supported by the national advertising campaigns and getting synergy between these working parts is a process of constant review.

“We continue to develop our champions – the people who are most affected by this issue – and we draw on a variety of knowledge, skills and experience and take a team approach to finding solutions.

“Basically, we know we’re in here for the long haul and change does not happen overnight.”

“Over the last year, the Like Minds, Like Mine project has been starting to make the transition from participation to the leadership of people with mental health problems...we will need to learn to identify as major drivers at the centre of the project – with all the uncertainties, complexities and difficult decisions that this brings.” Mary O’Hagan

What are the challenges for Like Minds, Like Mine?

Key challenges facing the programme include maintaining the momentum of the programme, not only with the regional and national providers but also keeping it fresh and relevant for the New Zealand public.

Like Minds, Like Mine needs a long-term vision and objectives and then hard work over a long period to achieve them. Like Minds, Like Mine is in the process of finalising the National Plan for the next six years. It will be launched later this year and will guide the programme through to 2013. The framework within which the programme operates will allow for measuring progress.

The plan will see Like Minds, Like Mine focus on building strong links between providers and other partners and allies to change behaviour at individual, organisational and policy levels.

Future Focus

So what is Like Minds, Like Mine aiming for? The vision of the programme has always been for a nation that values and includes all people with experience of mental illness. To achieve this it needs:

• To increase community ownership of Like Minds, Like Mine by giving people confidence in what they can do differently. People need to know what they can do to be more supportive.

• To develop relationships with more partners and allies who are “walking the talk”.

• To learn how to work with particular audiences and sustain a media presence that works. By developing key relationships we may see media reporting that looks beyond perpetuating associations between mental illness and violence.

• To continue to support the leadership of people with experience of mental illness.

Darryl says that desired outcomes will be achieved by building on the strong platform Like Minds, Like Mine has. “But awareness raising was the easy part, the hardest is yet to come.

“We need to keep the topic at the front of peoples’ minds and then work hard to bring about the needed changes.”

“Most of all,” says Darryl, “we need to keep focused on the positive and challenge discrimination wherever it occurs.”

Darryl Bishop was a guest presenter at the Enhancing Our Com(mon)unity conference in Rotorua in April.
What you do makes the difference

Like Minds, Like Mine – Phase four television commercials

“I don’t want pity, pity is not going to solve anything, but practical things are going to help.” Aubrey, Like Minds, Like Mine, TV ads.

July 16 marked the launch of phase four of the Like Minds, Like Mine TV ads.

There are five TV ads in this series and they all focus on the interaction between Aubrey, who has experience of bi-polar disorder, and the significant people in his life (family, friends and work colleagues).

The ads have a key message for viewers to take away – inclusion, ‘I know how I can be more supportive’.

“It’s not so much about the personal experience of mental illness itself,” says Darryl Bishop, Like Minds, Like Mine Programme Leader, “But rather the social experience of mental illness, with priority on how Aubrey and his family, friends and work colleagues addressed stigma and discrimination and the specific behaviours which were supportive in his recovery.”

The TV ads aim to show viewers appropriate, supportive and non-discriminatory behaviours in contexts that they can mimic. They also emphasise the importance of ensuring that people with experience of mental illness are included in, and can contribute to, everyday situations.

Dame Susan Devoy, Chairperson, Sport Bay of Plenty, who features in two of the ads as Aubrey’s past employer says “The greatest gift that Aubrey gave all of us was the ability to talk about it [mental illness].”

In the ads, she explains how Aubrey mentioning his mental illness was quite a conversation stopper at times.

“When someone says so-and-so has a mental illness, their immediate reaction to that person changes – that’s the really sad thing.

“They don’t take them for who they are, they suddenly think about what they are.”

But Susan says that Aubrey’s bi-polar disorder was no big deal to her and she just treated him like everyone else.

She says, “Aubrey made it easy for everyone because he was so open about his bipolar disorder – which meant he was generally well-accepted amongst his colleagues.

“Having Aubrey work in our organisation, the payback was that Aubrey was part of creating a culture that you could never buy.

“He challenged us all the time to think about how we could help others and having someone with a mental illness in your workplace teaches you a whole lot of things you don’t learn in any university, or learn from any books.

“It teaches you about tolerance and patience and empathy and support – and about looking after people and at the end of the day I believe the greatest resource in any organisation is its people.”

Susan’s advice for other employers is to:

• Make it your business to find out about the condition people have, otherwise you can make assumptions that are simply not true. The best way is to sit down with the person and ask what the mental illness means to them so that you can understand it from their perspective.

• Ask the person what support they need.

• Normalise as much as possible – people don’t want sympathy.

• Build policies in your workplace that respect people’s unique differences.

Aubrey believes that you should take every person as they are, “There are things that make them good at the job and things that make them bad at the job, but mental illness is not a factor that is going to impact on the job if the right supports are in place.”

Aubrey worked with Sport Bay of Plenty (in conjunction with the Halberg Trust) as a Sport Opportunity Advisor for three years. He facilitated the participation of children who had disabilities into sports and other physical activities.
“We’ve found that NZ has become a more socially inclusive society for people with experience of mental illness,” says Ruth Harrison, Chair Commissioner, Mental Health Commission.

Why publish the report?
Ruth says, “The Commission felt that it was timely to look back over the decade and review what developments have occurred since Judge Mason’s landmark report.

“The two most significant developments have been the adoption of a recovery-based approach with the services and the whanau ora approach to the delivery of mental health services.”

Other achievements include:
• Mental health services became more responsive to service user needs during the decade
• The past decade has been a time of increased quality service development
• Celebration of the progress towards achieving the vision of recovery and whanau ora
• New Zealand has become a more socially inclusive society for people with experience of mental illness
• The role of the mental health workforce, families and whanau and service users in supporting the vision of recovery, whanau ora and social during this decade

Profile on Gavin Pike from pages 163–164 of the report.

Gavin Pike, Kaiwhakahaere, Mana Mental Health Services, Rotorua

In 2001, Gavin Pike had a vision to create a “whaiora-led service” in the Lakes area. Gavin, who had been “accepting mental health services since 1995”, says: “My own sense of vulnerability made me realise the importance of not discriminating against people with mental illness.”

Gavin chose “Ruia mai nga kakano: Sowing the seeds to recovery” as Mana Mental Health’s whakatauki. Illustrating his vision for recovery, Gavin explains that with the right nutrients, a seed will eventually grow and develop branches. Some of these branches may wither and die, but others go on to develop blossoms, which produce fruit. He likens these seasonal changes to tangata whaiora who undergo transformative life processes. With the right support, tangata whaiora can develop healthy lives. Opportunities for recovery are increased when whaiora can access supportive services and make informed choices about their future pathways. Tangata whaiora supporting tangata whaiora is the key to this outcome.

Getting Mana Mental Health Services up and running has not always been easy. The time and energy Gavin has invested in creating the service reflects his commitment to recovery. He periodically struggled with his own unwellness, and at times received “a lot of flak” from people who did not share his vision. However, in 2005 Lakes DHB decided to pilot a two-year service to provide consumer peer support. Gavin was contracted to develop and deliver the service.

In April 2006, Mana Mental Health Services, a non-clinical and recovery-focused service based in Rotorua, was launched. Gavin leads a multicultural team of one administration person and three tangata whaiora who provide peer support and advocacy for tangata whaiora and whanau, either at the centre or in their homes. The service is inclusive of all people, regardless of gender, culture or ethnicity. With the support of his partner, Hui-Aroha Mareikura, and the Lakes DHB contract, Gavin’s vision to provide a peer advocacy service for tangata whaiora and whanau is finally being realised. Gavin’s indigenous values and beliefs reflect whanau ora in action when he states, “Who else better to provide awhi and manaakitanga but us? We understand!”
Challenges

The challenge for the Commission and the sector will be to ensure the debate Te Haererenga generates takes us forward on a path consistent with the goals established in Te Tahuhu, the second national mental health plan. Key challenges include:

- The rights of people with experience of mental illness
- The operations of the statutory framework for protecting their rights
- To ensure we are consistent in the way we define performance expectations and measure performance against these expectations.

What is the future?

Professor Mason Durie believes that the gains made over the past decade represent major transformations for the mental health sector and have positioned the country well to move into the next phase of development.

However, Ruth Harrison believes there is still more progress to be made.

“Te Haererenga is a retrospective of the last ten years and a springboard into the future.”

What will that future look like? “By 2015, I hope that the collective efforts of all of us working together will move mental health into a wellbeing-wellness model.

“We can’t stop people from experiencing mental illness, but we can support them in a life that is not just ‘living with’ mental illness — but thriving.

“The Commission is looking forward to playing a lead role in helping shape the services of mental health and addiction services in the future.”

For more information or to obtain a copy of the report, contact the Mental Health Commission on:

Ph: (04) 474 8900
Email: info@mhc.govt.nz

News in brief

New Zealand Mental Health Media Grants 2007

“There’s been a fantastic response to the first year of the New Zealand Mental Health Media Grants,” says Judi Clements, Chief Executive, Mental Health Foundation.

“In fact, with a sudden increase in interest towards our 31 May deadline, we had to extend it by a further two weeks to allow time for people to get their applications in to us.”

More than 40 applications were received over both category one (media professionals) and category two (creative media projects).

At the time of printing, the two selection panels were still making their final decisions, so we’ll be introducing you to the recipients and their projects in the next issue.

Winners at the inaugural Innovation and Excellence Minifest 2007

Counties Manukau District Health Board’s (CMDHB) Mental Health Services (MHS) held their first Innovation and Excellence Minifest earlier this year. The celebration aimed to recognise and share some of the excellent work that people in this sector have achieved and reflected a growing sense of partnership and collaboration between service users, the mental health provider arm and NGO services.

Services and individuals were invited to submit oral presentations and/or posters about any process or outcome that demonstrated improved outcomes for mental health services users in CMDHB:

- Nineteen presentations were submitted with eight selected for oral presentation.
- Eleven posters were entered from a wide range of services within the provider arm and across NGO mental health services.

The innovation celebration provided an opportunity to display the achievements of mental health service initiatives and give recognition to its champions. Participants developed confidence and pride in their achievements.

2007 winners were:

Best (equal) Service Innovation Poster
Kyros Karayiannis and Russell Murphy, The Cottage CMHC. Recovery and Borderline Personality Disorder: Living Life to the Full

Best (equal) Service Innovation Poster

Best Service Improvement through Audit Cycle Poster
Barbara Anderson and Monika Divis. Affinity NGO. Better Together: Towards Excellence in Strengths Model Practice

The event was considered a huge success and a number of participants made submissions to the 2007 CMDHB Sciencefest as a result. Another Minifest is planned for 2008.

Best Oral Presentation
John Wells, Julie Seuseu, and Caroline Mellers
Partnership in Evaluation Towards Recovery “PER” team.

Consumer-led Evaluation of Clinical Services: Report on the First Year

Runner-up: Oral Presentation
Michael Harris, Kathy Moore and Amanda Stokes
Safe Practise and Effective Communication: Promoting Safer and Therapeutic Services

John Wells, Partnership in Evaluation Towards Recovery “PER” team, accepting first prize from Dr Sue Hallwright, General Manager of Health Development.
How do we achieve social inclusion?

Continued from front cover

The answer lies in us working together at all levels (as individuals, families, friends, colleagues and organisations) and in all our different environments (home, work and in the community).

Creating socially inclusive communities is not just up to mental health services, but needs support from the wider community and intersectoral collaboration.

There are many opportunities for mental health service providers to facilitate social inclusion of people with experience of mental illness. In some cases being ready for these opportunities requires a willingness to shift to a more recovery-oriented approach and a recognition that one’s role may need to move toward working with families, community organisations, employers, educational institutions or a range of other groups.

In Dr Samson Tse’s recent MindNet article (see www.mindnet.org.nz), he says there are key strategies to promote social inclusion in a community and includes the following four specific actions from the United Kingdom based Social Exclusion Unit to break the social exclusion cycle:

- Address attitudes and beliefs
- Promote employment opportunities
- Support families and community participation
- Address housing, finances, transport and access issues.

Aaron Woolley believes that social inclusion can be achieved through consumer support, involvement and participation. “People with experience of mental illness should be considered as equal partners in decision making and strategic planning,” he says.

“If they are always consulted and informed, then together we can find a way to build on the strengths and to walk the journey together as ‘Like Minded’ people!”

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L I K E  M I N D S , L I K E  M I N E

Whakataua to Whakawhia i tō Tangata

The project to counter stigma and discrimination associated with mental illness is an initiative of the Ministry of Health.

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