



“Like Minds, Like Mine”: the campaign against stigma and discrimination (A)

Like Minds, Like Mine national manager Gerard Vaughan pressed “play” on the video in his Ministry of Health office in Wellington and once again reviewed the television advertisements prepared for the third phase of the nationwide New Zealand project to counter discrimination associated with mental illness. It was early 2003 and Vaughan knew his media campaign was at a crossroads.

The first two phases, a risky step into very new territory for mental health, had been highly successful. Seeing the ads showing All Black¹ John Kirwan and other New Zealand and international celebrities succeed in spite of mental illness had captured people’s interest and broadened their understanding. But attitudes to conditions such as schizophrenia had shifted only slightly. Māori and Pacific people identified with the ads less than Pākehā.² And it was one thing to increase public awareness, another to change people’s behaviour in ways that really reduced discrimination. While some people who experienced mental illness felt the campaign had made positive changes to their lives and family relationships, others felt the ads were at risk of creating a celebrity cult that had little to do with their own reality.

Vaughan was confident the latest series of advertisements addressed most of the issues. Instead of celebrities, they featured “ordinary people”, Māori and Pacific as well as Pākehā. He felt public understanding would be enhanced if the ads also used diagnostic labels to reveal the mental illness experienced by each person in the ads, something that had deliberately not been done before. Some members of his media advisory group who experienced mental illness were vehemently opposed to the idea and even his research company had misgivings. However the people featuring in the

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¹ The All Blacks are New Zealand’s national rugby football team.

² Māori are the indigenous people of New Zealand: Pākehā refers to non-Māori people of European origin. New Zealand’s population, according to the 2001 census, was 15 percent Māori, 7 percent Pacific Island origin, and 78 percent European or other.

ads felt happy with how they would be presented, as was the production team that had worked on each phase of the campaign. There had been extensive testing and lengthy debate. Vaughan would have to make the call himself.

Major shifts in mental health care

Until the 1970s, people with mental illness in New Zealand were cared for primarily in institutions. At the peak, ten large psychiatric hospitals housed over 10,000 inpatients at any one time³ out of a total population of around three million.

Deinstitutionalisation introduced a new era in mental health. By the mid-1990s all the older-style psychiatric institutions had closed or were closing, replaced by a substantial growth in community-based services.⁴ Recognising the need for coordinated mental health services, in 1994 the government published *Looking Forward*, a national mental health strategy.

Alongside the move to community care came a new focus on the rights, participation and leadership of people who experienced mental illness. In 1986, the World Health Organization developed the *Ottawa Charter for Health Promotion* which defined health promotion as “the process of enabling people to increase control over, and to improve, their health” and stressed that it went beyond healthy lifestyles to wellbeing.

Meanwhile in New Zealand:

- Service user organisations began to emerge including, in 1990, the Aotearoa⁵ Network of Psychiatric Survivors.
- In 1994, an amendment to the Human Rights Act made it illegal to discriminate on the basis of disability in employment, housing, education or the provision of goods and services. Mental illness was included as a disability.
- In 1995, the Office of the Health and Disability Commissioner was set up to protect the rights of consumers, and the Ministry of Health published *A Guide to Effective Consumer Participation in Mental Health Services*.

Mason inquiry

In three high-profile cases in 1995, police shot and killed armed men who were mental health service users. This fuelled public anxiety about the effectiveness of community services (although later studies showed that homicides by people who experienced mental illness did not increase per head of population between 1970 and 2000.)⁶ After the third incident, the government ordered a ministerial inquiry, and appointed Judge Ken Mason

³ Mental Health Commission, 2007, ‘Te Haererenga mo te Whakaōranga 1996-2006: The Journey of Recovery for the NZ Mental Health Sector’, Wellington, April (“The Journey of Recovery”).

⁴ Simpson, A et al, 2004, ‘Homicide and Mental Illness in New Zealand 1970-2000’, *British Journal of Psychiatry*, November, 185: 394-398.

⁵ Aotearoa (“land of the long white cloud”), is the traditional Māori name for New Zealand and widely used.

⁶ Simpson et al

(Ngai Tahu)⁷ as its chair. While better service coordination and public safety were the catalysts, there was also an element of political damage control.⁸ It was the sixty-seventh inquiry into mental health since 1987 - though most had focused on specific incidents⁹ - and the third chaired by Mason. In his previous inquiry, he had looked into procedures in some psychiatric hospitals, drawing attention for the first time to the prominence of Māori in mental illness statistics.

The latest inquiry only had three members: Mason, a lawyer and a senior field worker from a major voluntary mental health service provider. Unusually, there was no one with a medical background. Nor was it based in the capital city, Wellington. Many hearings took place informally in hospitals, prisons and marae.¹⁰ Of the 720 submissions received – three times as many as expected - more than 400 came from individuals. There was also a distinct Māori voice.

Mason’s report, delivered in May 1996, was damning. It identified a lack of national leadership and said “all services, including crisis support, assessment, treatment and continuing support are fragmented and under-resourced, both in skills and size”.¹¹ Around half of the report consisted of direct testimony, giving a very human face to the experience of mental illness. Family members were well-represented:

- Sisters speaking about their uncle: “Where families are willing, these people must have an involvement in the care, the progress and the overall treatment of their family member. This will help them to feel a part of that person’s life again, to be of use, to help and be helped.”
- An older sister: “Crisis support for us has been non-existent. When my sister was threatening to take her own life, the quickest appointment she could have was over a week away.”
- A mother: “The week before our daughter took her own life, I phoned the psychiatrist to say that she had put up a ‘noose’. The psychiatrist asked if I had my daughter’s permission to call.”

The voices of people who experienced mental illness featured less strongly.

- The Aotearoa Network of Psychiatric Survivors said, “most of our needs are identical to anyone else’s – a liveable income, secure housing, work, friends, intimate partners and self esteem.”
- The only consumer in the report described “the cold, hard way” of the people working in Emergency Psychiatric Services and said they should not work there “unless they

⁷ The Māori iwi (tribe) with which Mason identifies.

⁸ Brunton, W., 2005, ‘The Place of Public Inquiries in Shaping New Zealand’s National Mental Health Policy 1858-1996’, Dept of Preventive and Social Medicine, Otago University, October.

⁹ “The Journey of Recovery”, p1

¹⁰ The marae, which includes public space, a meeting house and catering facilities, is the ceremonial and spiritual centre for iwi.

¹¹ Mason, K., J. Johnstone and J. Crowe (1996): “Inquiry under section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Jenny Shipley, (“The Mason Report”), p100

have a compassionate heart or the good sense to know what would help the person in trouble.”

Mason made only five formal recommendations. Most, including increased funding and the establishment of a Mental Health Commission, had been anticipated. But the call for a public awareness campaign took almost everyone by surprise. “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,” he said. “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.”¹²

Government’s response

With a general election looming - the first under the MMP (Mixed Member Proportional) electoral system¹³ - the National government promised to fully fund and implement all the report’s recommendations. The Coalition Agreement signed by National and New Zealand First in December 1996 endorsed the recommendations. It also softened the 1993 health reforms, proposing to replace the four Regional Health Authorities with a single national purchaser (the Health Funding Authority) by July 1998, and giving greater emphasis to “health gain”.

Funding and responsibility for implementing the Mason Report recommendations rested with the Ministry of Health, the government’s principal agent and advisor on health and disability issues. Staffing in the Ministry’s mental health unit was doubled and funding for services increased by \$142.2 million. A Mental Health Commission was set up, although there was some criticism that it was a “tightly-focussed” body with a “watch-dog role” rather than the quasi-department envisaged by the inquiry.¹⁴

In 1997, a five-year, \$12.6m¹⁵ project to counter stigma and discrimination associated with mental illness was launched. The Ministry was responsible for a national media campaign and national coordination of the project, while the four Regional Health Authorities funded and oversaw community-based programmes in their areas.

The prospect of mounting a media campaign challenged the Ministry’s mental health unit which had no experience in social marketing; its primary focus was on the treatment of individuals and the administration of legislation. It sought advice from the public health unit, used to running population-based public education campaigns on issues like smoking cessation and immunisation.

¹² “Mason Report”, p 164.

¹³ Under MMP voters have two votes, one for an electorate and one for a party, so that parties with little or no electorate representation can still have a significant presence in parliament through the “list” MPs brought in on the party vote. MMP is generally regarded as having greatly increased the diversity of representation in Parliament; no party has won a clear majority since it was introduced, so all governments have been coalitions.

¹⁴ Brunton, W. (2005) ‘The Place of Public Inquiries in Shaping New Zealand’s National Mental Health Policy 1858-1996’, Dept of Preventive and Social Medicine, Otago University, October.

¹⁵ All figures in New Zealand dollars. In 1997, one New Zealand dollar averaged \$0.66c US.

This alliance was crucial, said Gerard Vaughan, then Ministry mental health communications manager and later Like Minds Like Mine national project manager. “Most prevention and promotion campaigns overseas had grown out of the treatment area and were only partially successful because of the difficulty of separating individual mental health problems from wider community awareness.”

However, mental health did not fit easily with traditional public health approaches. Susie Crooks, head of the Light House Trust, a consumer-run mental health service in Napier, was involved in the project from the beginning. You couldn’t advise people to reduce mental illness by eating properly or getting eight hours sleep, she said. And there were no easy benchmarks of success, such as the number of people that have given up smoking. “You couldn’t stop having schizophrenia.” Encouraging people to access health services didn’t work either, because the worst place for experiencing stigma and discrimination was within health services themselves, Crooks said.

Community readiness

When 25-year-old Stephen Anderson shot dead his father and five other people in the tiny North Island town of Raurimu in February 1997, plans for a national awareness campaign were put on hold. Anderson had been diagnosed with schizophrenia and new Minister of Health Bill English was concerned that the public would see it as the government passing the buck instead of investing more money in mental health services.

With hindsight, this was just as well, Vaughan said. “When people say ‘social marketing’, they just think ‘marketing’. We realised that we needed to build local support and have a community conversation before we could really begin to change public attitudes.” International research confirmed the wisdom of a broad-based approach. Evaluation of an Australian mass media campaign to reduce discrimination in 1995 showed that, though reasonable results were achieved, greater involvement of community groups might have led to greater success.¹⁶

Regionally, the new project faced setbacks as well. Lack of coordination between the four Regional Health Authorities “allowed each funder and a wide range of providers to pursue very different approaches, values and principles. Consequently, relationships among stakeholders were very poor”.¹⁷ Central RHA contracted solely with public health units that had no experience of reducing stigma and discrimination and no formal process for consumer participation. Other RHAs funded local organisations, some Māori, some consumer-based, often with different models and philosophies about mental illness.

From the start of the project, there was a strong emphasis on research and evaluation, at least partly to justify the expense. In the absence of specific information about discrimination against people who experienced mental illness, early researchers looked at racism, gender issues and homophobia.

¹⁶ Ministry of Health, (1999), Like Minds National Plan

¹⁷ Ministry of Health (2001), Like Minds National Plan, 2001-2003 (June)

A literature review by the Central RHA in 1995 had identified the key influences on changing attitudes as (in order of effectiveness) direct contact with people who experienced mental illness; indirect exposure via the media; and information and persuasion.¹⁸ Exploratory research into public attitudes to mental illness was also carried out by BRC Marketing and Social Research in 1997.

Meanwhile, the Ministry of Health continued to develop and refine its mental health policy. In 1997, it published national mental health standards and a national plan called *Moving Forward* that included an objective to “improve responsiveness of mental health services to consumers”. The following year it released a national youth suicide prevention strategy.

The “conference from hell”

By 1998, the need for better coordination and a national focus for the project was clear. Huia Communications, a public relations company, was brought in to help organise a national mental health provider conference in Rotorua in March. Huia also provided ongoing coordination and communication support (newsletter, website, fact sheets) and later facilitated media training.

Crooks said people who experienced mental illness still referred to that first conference as “the conference from hell”. They were invited at the last minute and nobody realised their high level of dissatisfaction with providers and health services, including the Ministry. “In those days we called it the Ministry of Illness rather than the Ministry of Health. They seemed to be more about protecting their stakeholders, who were not the patients.”

Nonetheless, the vision that emerged from the conference was “working towards creating a nation that values and includes people with mental illness”. It was followed by a hui¹⁹ for Māori stakeholders that adopted the slogan, “whakaitia te whakawhiu i te tangata” (reduce your potential to discriminate), and a fono²⁰ for Pacific stakeholders. A working group came up with the name “Like Minds Like Mine”, a play on the phrase that “we are all of like mind”. It also oversaw a consumer art competition that produced the Like Minds logo, the maths symbol \geq which in the project means “greater than discrimination, equal to others”.²¹

First national coordinator

In 1998 the Health Funding Authority took over as the single purchaser for both national and regional Like Minds activities. Psychologist Janet Peters was appointed as the

¹⁸ Like Minds National Plan 2001-2003, p4 (Barwick H, ‘Positively Influencing Public Attitudes to People with a Psychiatric Disability,’ Wellington: Central Regional Health Authority, 1995)

¹⁹ A hui is the Māori word for a consultative gathering usually held on a marae (where a meeting house is located).

²⁰ A fono is the Pacific equivalent of a hui, and would often be held in a church.

²¹ Ministry of Health, 2004, Like Minds, Like Mine Orientation Kit; a guide to Like Minds people, activities and resources (July), p7

project's first national coordinator. She was a good choice, Vaughan said, having both clinical credibility and a good understanding of stigma and discrimination.

Peters drew up a national plan and set up two advisory groups: one representing stakeholders (the National Stakeholder Group), the other made up entirely of people who experienced mental illness (the Consumer Advisory Group). There was no formal selection process for the second group. "In some regions people were nominated, in other regions it was really just who was available," Crooks said. This left members of the group vulnerable to the accusation they were not representative.

Recovery/whānau ora

The importance of involving people who experienced mental illness²² was highlighted by the Mental Health Commission in its *Blueprint for Mental Health Services and Travel Guide*, both published in 1998. The concept of recovery - defined as happening when people can live well in the presence or absence of mental illness – was identified as a fundamental value. In the recovery approach, mental illness is seen as having some positive aspects for the individual and their community, as well as bringing challenges, losses and disability. Service-user leadership is seen as crucial.

Although recovery is an international movement, New Zealand is thought to be the first country to have endorsed the concept in its national mental health strategy. The *Blueprint* also acknowledged that for Māori, mental health is rooted in cultural identity. From this emerged the much broader concept of whānau ora,²³ whereby the whānau plays a central role in the health of its members, and pathways to well-being are focused on building whānau capacity.²⁴

Second national project manager

In 1999, Warren Lindberg replaced Janet Peters as the Like Minds national project manager, although Peters remained a key resource during the development of the media campaign. Lindberg brought 12 years experience of public health promotion as director of the New Zealand AIDS Foundation, and a background in teaching and community work. He was a good communicator who worked in a very inclusive way and developed wide support for the project, Vaughan said. "He was also a bit of a personality so he gave it a profile."

Lindberg had an affinity with people who experienced mental illness. "Warren used to say that for the first 30 years of his life he was a consumer because homosexuality was in the DSM²⁵ book of diagnosis," Crooks said. He found a budget for the Consumer Advisory Group (renamed the National Advisory Group) and began to pay people to attend

²² People with experience of mental illness/service users/consumers/tangata whaiora ("people seeking wellness") are all accepted descriptions. (Ministry of Health, 2004, Like Minds, Like Mine Orientation Kit; a guide to Like Minds people, activities and resources (July) p 10.

²³ Literally, health (ora) of the extended family (whānau).

²⁴ 'The Journey of Recovery', p 9

²⁵ Diagnostic and Statistic Manual of Mental Disorders

meetings although their other work was still under-funded. “I think at one stage I was getting [paid for] ten hours a week and probably doing forty,” Crooks said. “In a way it was tokenistic, but in another way it was a natural evolution.” The group gave people the opportunity to meet and talk regularly at a national level, greatly strengthening the consumer movement.

Lindberg hit the ground running. On his first day, he sat on the panel to select an agency to make the Like Minds TV advertisements. Social marketers Foote, Cone and Belding (FCB)²⁶ were chosen. There was \$4 million to be allocated over two years, of which \$1.8 million went to the media campaign and \$2.2 million to the regional activities. The Ministry of Health’s brief specified “Advertising will seek to raise awareness that people who have or have had a mental illness experience discrimination and will seek to make this an issue relevant to the general public. Advertising will be relevant to a range of audiences, including mainstream, Māori and Pacific audiences.”²⁷

Phoenix Research had been brought in to assess the impact and measure the ongoing effectiveness of the campaign. The benchmark survey they conducted in 1999 fed into Mind and Mood workshops organised by FCB, and BRC’s 1997 survey results. The following challenges were identified:

- People had a low level of understanding of, and interest in, mental illness.
- News and entertainment media played a major role in what people knew about mental illness.
- The commonality of mental illness was not understood. For example, the public did not see “mild depression” as an illness and regarded “serious mental illness” as “not my problem”.
- European/Pākehā, Māori and Pacific peoples viewed mental illness differently.
- Youth and elderly viewed mental illness differently.
- People were not aware how they discriminated.
- People disliked “Government” or “preachy” messages.²⁸

Research had also emphasised that the campaign would also have to work for people who experienced mental illness.

These concepts were used to develop five potential advertising treatments which were then tested at 22 workshops featuring various stakeholders, including people with mental illness, Māori and Pacific people, and “the general public.” Following the workshops, three concepts were dropped and two new ones developed.

This set the pattern for development of each phase of the campaign. The final advertisements were arrived at through an iterative process of consultation and debate,

²⁶ Now known as DraftFCB

²⁷ Phoenix, October 1999, p7, cited in Daellenbach, K. and J. Carruthers (publication pending), Practice paper on “Like Minds, Like Mine”- a social marketing project to reduce the stigma and discrimination associated with mental illness, Victoria University of Wellington.

²⁸ Mental Health Commission (2004) Journeys towards equality: Taking stock of New Zealand’s Efforts to Reduce Discrimination Against People with Experience of Mental Illness, p10

designed to identify and learn from what was working and what wasn't. While data from an ongoing series of surveys underpinned decisions, less formal evidence such as the number of calls to the freephone 0800 number shown at the end of each advertisement was also factored in.

FCB's Brian van den Hurk said the logic was always to start with some broad thinking and look at options along a continuum which recognised that there will be an overlap between attitudes and behaviours, and the varying stages of readiness among audiences to accept messages. "Then we use feedback to refine and determine the direction we will move in."

The development process always involved lively debate. Views frequently diverged within as well as between groups. Pacific people were adamant the campaign needed a Pacific face. While one group argued that information for Māori would only be meaningful if it focussed on Māori, others argued as forcefully that such an approach would suggest that "madness was only a Maori problem" and it was important to show the commonality of mental illness. The consumer movement wanted the ads to go into more depth about how hard people's lives were. The strong push to feature young people came up against evidence that young people had little empathy with their own age group as they thought someone young with a mental illness was a result of drug use and therefore their own fault.

Phoenix Model of Change

Phoenix developed a model of change (*Exhibit 1*) that had people who had experienced mental illness at its centre. The main areas it identified to reduce stigma and discrimination against people who experienced mental illness were:

- empowering mental health consumers and family/whānau;
- changing attitudes and behaviours of the media, opinion leaders, service providers and the public;
- mass media advertising; and
- improving policy.

By showing how each group influenced public opinion, the model helped to pinpoint the best anti-discrimination activities. People who experienced mental illness were also most effective in changing the attitudes and behaviours of the other groups. "All initiatives had to have the buy-in, support and involvement of this core group," Vaughan said.

One direct result was the establishment of "Community Voices" training to support people who experienced mental illness in telling their story through public speaking engagements. Speakers bureaux were set up to support and administer the training, and to make sure that public disclosure was safe. This was also an important consideration for the people who were asked to feature in the nationwide media campaign.

The first nationwide campaign

In February 2000, Lindberg launched the first series of TV and radio advertisements which took the innovative and risky approach of using real people – New Zealand and international celebrities – speaking about their experience of mental illness.

“The general public wasn’t interested in mental health issues and didn’t want to talk about them,” Vaughan said. “Schizophrenia equalled mental illness in most people’s minds and it was too scary. People who experienced mental illness were afraid to bring their skeletons out of the closet in case of a backlash.”

But the project was getting close to the end of its five-year life and decisions had to be made rapidly. It was understood that changing discriminatory behaviour would not happen overnight. The earliest and easiest objective was to get the public to recognise how common mental illness is, then they could discover they were discriminating and develop ways to change their behaviour.²⁹

In preparation for the TV ads, FCB researched a range of New Zealand and international celebrities known to have experienced mental illness. Recognising the high risks involved they worked closely with Janet Peters who advised on the elaborate steps to be taken to ensure that participants and their families would feel safe throughout the process. This included an open-ended provision to withdraw themselves, or material featuring them, at any stage.

FCB chose as director Kevin Denholm who, in a series of documentaries filmed in prisons around the world, had gained people’s trust through his genuine interest in telling their story.

With preparations in place and potential interviewees identified, some “incredibly awkward conversations” took place, Brian van den Hurk recalled. “We had a group of people who were really interested but were incredibly nervous about the whole endeavour. There was no history of something similar being done.”

Once former All Black, John Kirwan, approached through a rugby connection at FCB, agreed to take part, other people also seemed more comfortable to come forward. Kirwan had revealed in his 1992 biography that he had grappled with severe depression, a courageous decision when international rugby players symbolised toughness.

The advertisements, which screened throughout 2000 and 2001, presented two montages of familiar faces, one with well-known New Zealanders, and the other in which international names like Winston Churchill, Sir Laurence Olivier and Audrey Hepburn were interspersed with local celebrities like designer Denise L’Estrange-Corbet, musicians Bunnie Walters and Mike Chunn, writer A K Grant, and Kirwan. At the end, a voice-over said “these people were affected by mental illness. They weren’t judged by it. One in five

²⁹ “Journeys towards equality”, p10

New Zealanders is affected by some degree of mental illness at any time. How much they suffer depends on you. Are you prepared to judge?”

Though none of the featured people spoke during the ads, Denholm had interviewed most of them at length, sometimes including friends and family in conversations designed to bring out key messages. According to the agreed protocol, a few participants decided they wanted to withdraw, even after the ads went to air.

“We were always aware that we were working with very vulnerable people, who might not always be in such a good space,” Brian van den Hurk said. “We knew there was a risk the whole project might have to stop.”

Research by Phoenix showed a very positive response to the advertisements. Material from the interviews was used to make a one-hour documentary, *Sticks and Stones*. The film went into more detail about the lives of some of the people featured. It aired twice on prime time television and was a top-rating show, attracting 300,000 viewers.

The success of the advertisements exceeded everyone’s expectations and generated wider media interest, as well as a significant number of calls to the free phone number listed at the end of each ad.

“Quite a few people came out that weren’t even connected with the campaign,” Crooks said. “There were quite a few magazine stories and radio programmes and articles. I’ve got my one framed. It became quite a fashionable topic.” The ads also strengthened the Like Minds project as a whole, building confidence in its powerful potential to reduce stigma and discrimination.

Recognising the media’s important influence on attitudes, the project produced a handbook for journalists and instituted a media award for coverage of mental illness. In partnership with the US Carter Centre Mental Health Journalism Fellowship Program, it began sponsoring two New Zealand journalists a year to write in-depth stories relating to mental illness. At the same time, media training was given to all regional Like Minds providers and supporters.

New directorates and a new director

From July 2000, the Ministry of Health adopted a new structure, with nine directorates each led by a deputy director-general. They were sector policy, public health, disability issues, mental health, personal and family services, Māori health, corporate and information, and sector funding and performance.

The Like Minds project came under the public health directorate, with the national project manager accountable to both Janice Wilson, Deputy Director General of Mental Health, and Don Matheson, Deputy Director General of Public Health. As before, the national manager was responsible for funding national contracts and coordinating them with regional funding and activities. Portfolio managers in the four former Health Funding Authority regions continued to manage regional contracts, with providers given some

autonomy as long as their activities were in line with the Like Minds national plan (*Exhibit 2*).

In 2001 Warren Lindberg was appointed a Human Rights Commissioner, a role that included responsibility for disability and mental health issues. He was replaced by Gerard Vaughan who already had a close association with the Like Minds project as the Ministry's mental health communications manager. Vaughan had a strong interest in evaluation and research, and several years experience working overseas in community-based organisations dealing with employment and disability issues. As he started his new job, the project's original five-year funding came to an end.

The project to counter stigma and discrimination had now become part of the core public health funding. Given the progress made in the first five years, and the understanding that change would take a long time, public health continued to commit the needed funding to keep the project going. Vaughan reflected that one aspect of the original funding package was a factor in the campaign's success. While there was a requirement to account each year for what had been spent, the \$12.6 million was "ringfenced" for five years, with no specified amount to be spent annually. This flexibility meant they could devote time to planning at the beginning, and have funds in reserve for the more expensive delivery phase of the media campaign and regional activities that came later.

By the time Vaughan took over the job, the National Stakeholder Group had been made redundant by annual stakeholder forums of 100 people or more. He inherited two advisory groups: the National Advisory Group of consumers, and a media group that oversaw the advertising campaign. The latter was made up of 10-12 people, of whom around four experienced mental illness. Māori, Pacific people, health professionals and communications experts were also represented.

Phase Two: "You Make the Difference"

The second phase of television advertisements, launched in 2002, built on the first, under the broad theme "You Make the Difference". Four one-minute ads each focused on a New Zealander from the first series with a friend, also well known, speaking as a supportive companion. High-profile TV frontman Paul Holmes said he wished designer Denise L'Estrange-Corbet (of "World") had told him about her mental illness sooner. Respected, Samoan-born former All Black Michael Jones said he was embarrassed not to have noticed John Kirwan's depression. Kirwan himself said: "I was clinically depressed, though I prefer to say I was freaking out. Depression is the kind of thing, people say to you 'snap out of it.'"

The tag-line repeated the message of the first ads that, at any point in time, one in five New Zealanders is affected by mental illnesses "like schizophrenia, depression and bipolar disorder." Again it asked, "Are you prepared to judge?"

The public loved the ads. However, some people who experienced mental illness were disappointed. "We were accused of only promoting nice mental illnesses," Crooks said. "People with the most difficulty gaining community acceptance were people who didn't

fit in. You know, they weren't wealthy, they weren't famous, they looked very unusual and often had terrible side-effects from years of institutionalisation."

Crooks understood the need to educate the public slowly but she felt the ads were too soft. "I used to joke with Gerard and Warren that I was waiting for phase ten when we were really going to lift the lid off some of the difficult issues around the project, one of them being that institutionalisation was one of the blackest periods in medical history...I don't know if it would have been that constructive, but the health sector needs to take some ownership for doing a lot of harm."

Vaughan recognised the advocacy role of many members of the media advisory group but was ultimately driven by what was going to work for the public. "It's not what you put in, it's what people take out of it," he said. The people chosen for the ads had to challenge negative stereotypes about mental illness. "The consumer movement were saying, 'Who are these people? They all look far too good. They're not like the mates I hang around with.' And I can entirely understand that. But we needed to be very focussed on our objectives and what we were trying to achieve through this arm of the work."

Other arms of the project had wider goals including educating the mental health sector. By 2006, almost half of Like Minds workshops were delivered to tertiary students, particularly those studying to work in the mental health sector, and over a third were delivered to frontline staff of mental health and other agencies such as the Department of Work and Income.³⁰

Both phases of the "famous people" media campaign were extremely successful. In 2002, the campaign won gold at the first EFFIE (Effective in Advertising) Awards. The following year, it won *Marketing Magazine's* supreme award, and the premier award in the advertising/public relations category of the Media Peace Awards. Ongoing evaluation by Phoenix Research (*Exhibit 3*) showed that public attitudes to mental illness had improved in almost all areas; positive behaviour changes included increased discussion of the topics raised by the advertisements, and people feeling that they were more accepting of people with mental illness.

Detailed analysis of ongoing research showed that attitudes to illnesses such as schizophrenia had shifted slightly. Although Māori and Pacific people still did not identify with the ads as much as Pākehā, there was encouraging evidence that Māori in particular were discussing the issue more often. Over half the people surveyed after the second phase of ads said they would like to know more about mental illness though there was still a very strong impression that once a person became ill, they would stay ill.

The John Kirwan ads stood out for their impact across all groups and ethnicities. Vaughan was often approached by people with experience of mental illness who described the "life-changing" validation they felt and support they had gained after John Kirwan's appearance, and said it should have been run "ten years earlier."

³⁰ 'What's Been Happening?' A Summary of Highlights, Activity and Progress on Like Minds, Like Mine 2003-2006', Ministry of Health, Feb 2007

But some of those who experienced mental illness felt the ads were at risk of creating a celebrity cult that had little to do with their own lives. In a Phoenix survey published in March 2003, people with experience of mental illness generally endorsed the campaign but asked for it to feature more ordinary people, and that education campaigns should target mental health service providers and government departments as a matter of priority.

At the same time, planning began for a much more extensive survey of people with experience of mental illness, aimed at identifying key areas where discrimination occurred, and describing discriminatory behaviours.

Phase Three: “Know me before you judge me”

As with the previous phases, a great deal of time and effort went into planning, researching and pre-testing the third phase of ads during the year leading up to their launch on television and radio in October 2003.

Vaughan was confident the latest concepts developed by FCB addressed most of these issues. Three everyday New Zealanders, including a Māori and Pacific person, replaced the famous people, showing how the support of family, employers and friends could assist in their recovery. The focus shifted from raising awareness to gently challenging people to think about their personal beliefs and attitudes. The message changed to “Know me before you judge me”.

Vaughan wanted to take the ads further and use clinical labels to reveal the mental illness experienced by each person. This had never been done before, but he felt it was a logical and necessary step. The labels – especially schizophrenia - were already being framed negatively by the media, the most significant influence on public perceptions, he said. They needed to be reframed in a positive context. He felt that by naming the illness it would ensure that viewers realised that the confident and articulate person on-screen was living with one of the illnesses the public feared most.

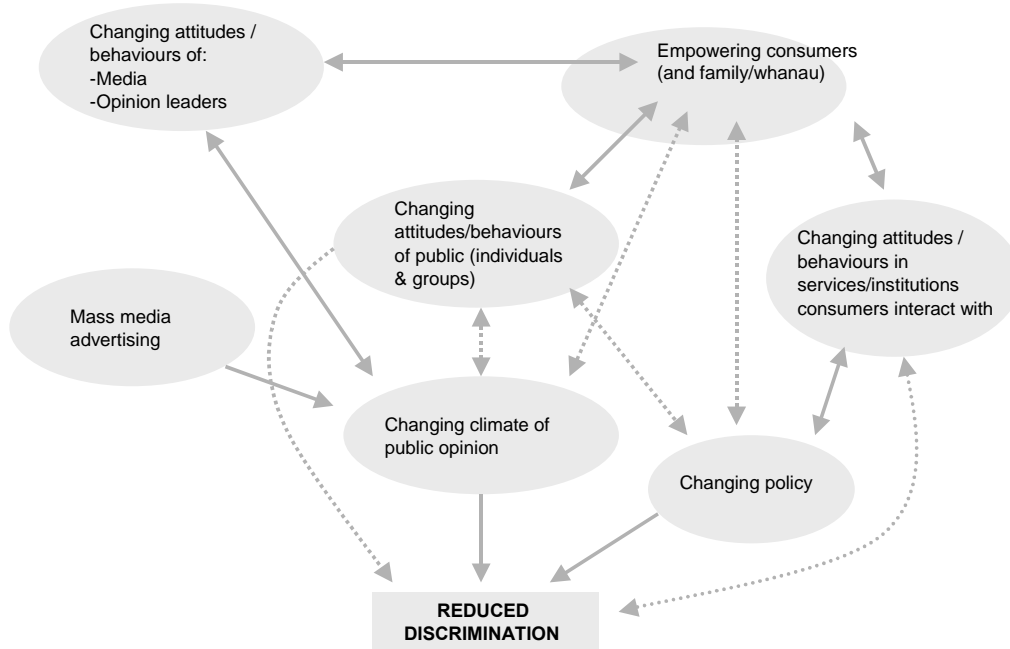
“Unless we identified the person’s illness, the risk was that people would say ‘Well, that’s all fine but there’s still these people with schizophrenia who are scary’. We would be having a parallel conversation.”

Some members of the media advisory group who experienced mental illness disagreed, one of the most vocal of them being Crooks, who was at the forefront of the social movement to reclaim the language around mental illness. “Most survivors of psychiatry see the diagnosis as an insult,” Crooks said. “So actually John Kirwan was very good because he used terms like ‘I was freaking out’. He didn’t use medical terms like ‘I was clinically or catatonically depressed’.”

Phoenix shared Crooks’ misgivings. Given the general public’s negative stereotypes, they questioned how safe it was for people in the ads to identify their mental illness.

In Vaughan's view: "The campaign had to work for people with experience of mental illness, but it also had to work for you and me." The debate appeared to be deadlocked. As project manager, Vaughan had to make the call.

Exhibit 1: Phoenix Model of Change for Reducing Discrimination and Stigma Against people with experience of mental illness



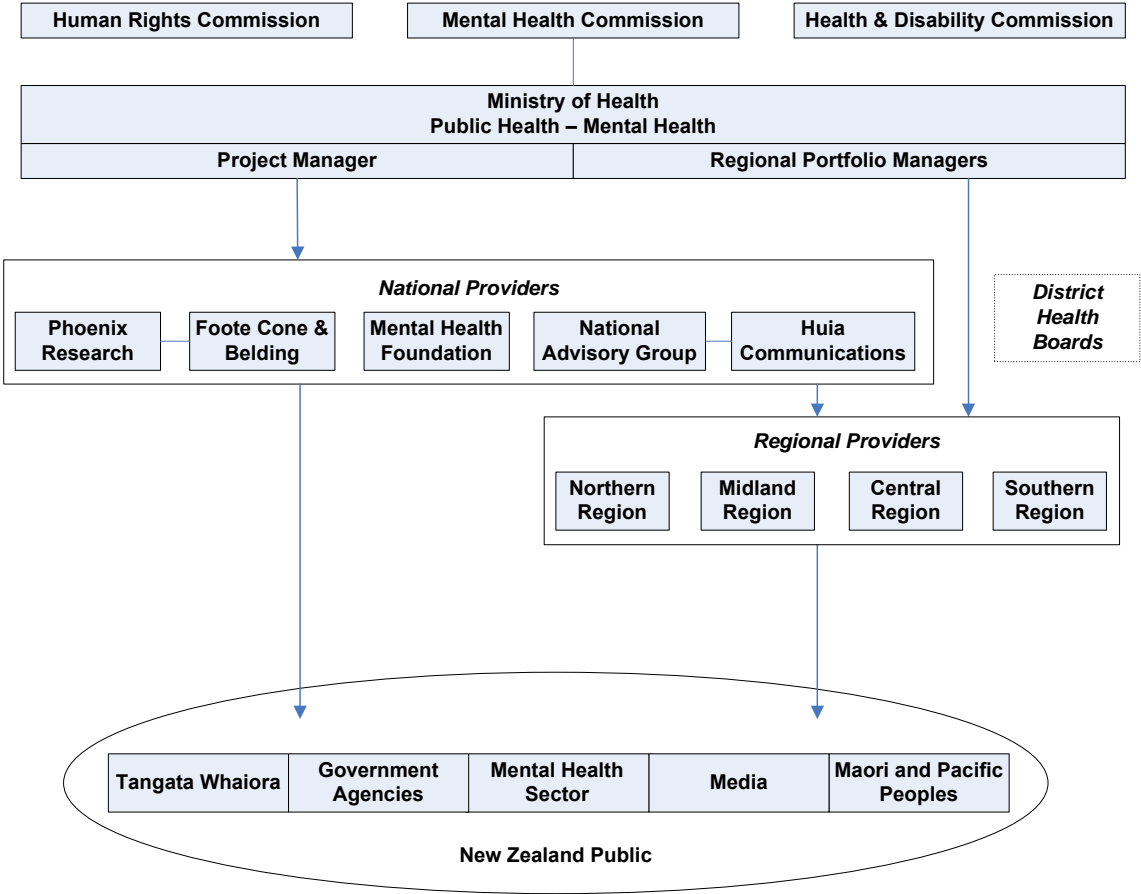
Source: Ministry of Health (2001) National Plan 2001-2003 Project to Counter Stigma and Discrimination Associated with Mental Illness.

**Table 1:
Relationship between the theoretical framework of the Ottawa charter, the key components identified by the model of change, and the Like Minds project objectives.**

Ottawa Charter	Model of Change	Strategic Objectives
Building healthy public policy	Changing policy	Change attitudes and behaviour in government agencies having frequent contact with people with experience of mental illness, through education and policy development
Creating supportive environments	Mass media advertising Changing attitudes/behaviours of media/opinion leaders Changing climate of public opinion	Change public attitudes and behaviour through media, public relations and community education activities
Strengthening community action	Changing attitudes/behaviours of public: individuals and groups Empowering people with mental illness and family/whānau	Change public attitudes and behaviour through media, public relations and community education activities. Address stigma and discrimination in Māori and Pacific peoples' communities through community education
Developing personal skills	Empowering people with mental illness and family/whānau	Empower people who have experience of mental illness and increase their involvement in the Project
Re-orienting health services	Changing attitudes/behaviours in services/institutions that people with experience of mental illness interact with	Work with the mental health sector to change attitudes and behaviour through education and policy development; Develop infrastructure and networks

Source: Like Minds Orientation Kit, page 10.

Exhibit 2: Linkages flowchart showing Like Minds project structure (2001)



Source: Ministry of Health (2001), "Like Minds National Plan 2001-2003", p 13

Exhibit 3: Impact of first two phases of the campaign – “Famous people”

	After first campaign	After second campaign
Unprompted recall	53%	79%
Prompted recall	67%	89%
Recall of messages “it can happen to anyone”	39%	32%
“People should be more accepting”	17%	27%
Prompted discussion at least once	n/a	73%
Prompted several discussions	n/a	30%

	Benchmark survey	After second phase
“People who’ve had a mental illness can still lead a normal life”	72% agreed	87% agreed
“People who have a mental illness are more likely than other people to be dangerous”	27% disagreed	30% disagreed
“I feel I am becoming more accepting of people with mental illness”	69% agreed	80% agreed

- There was no change in the proportion of people who said “I can see ways in which people with mental illness are discriminated against,” perhaps because the ads did not focus on specific experiences of discrimination.
- While attitudes towards mental illness generally improved, this was not the case with attitudes towards schizophrenia. This might be attributed to the deliberate decision not to use diagnostic labelling.

Source: Adapted from Mental Health Commission (2004) Journeys towards equality: Taking stock of New Zealand’s Efforts to Reduce Discrimination Against People with Experience of Mental Illness, p11-12.