Journeys Towards Equality

Taking Stock of New Zealand’s Efforts to Reduce Discrimination Against People with Experience of Mental Illness

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This report was prepared by Beven Yee and Hilary Lapsley, with input from our colleagues at the Mental Health Commission (special thanks to Mary O’Hagan, lead Commissioner for this project, Mark Jacobs, Sonja Goldsack, Philippa Sellens and Wendy Parker).

Research contributing to this project was conducted by Hamish MacKenzie, Claire-Louise McCurdy, Kay Saville-Smith, Bev James and Seth Bateman.

Gerard Vaughan, National Project Manager of Like Minds Like Mine, gave us helpful information and feedback, as did many others in government agencies and the mental health sector.
New Zealand is taking a leading role internationally in challenging discrimination on mental health grounds.

Across the world, different countries are beginning to strip away some of the barriers of prejudice and exclusion that prevent consumers from participating as equal citizens. For instance, in Britain the Government has agreed to lift the bar on jury service faced by consumers, and recently overturned the notion that people who have received psychiatric treatment in the last two years cannot work in health services. Now health services are actively encouraged to employ consumers in regular jobs and at all levels.

But effective anti-discrimination work is not just about big symbolic policy changes. It is about local and national activities by different groups and individuals that actually change behaviour and attitudes on a day-to-day level. This report shows that in New Zealand organisations have worked together to think with great clarity about the philosophies to underpin anti-discrimination work, and to provide shared, negotiated leadership for work around the country that is rooted in evidence of what is most likely to work. What is particularly impressive is the number of different sectors involved in anti-discrimination activities, ranging from consumer-run employment support to national advertising campaigns; from work framed in Māori, Pacific Island or Asian conceptions of mental health to the incorporation of anti-discrimination principles into the required competencies of mental health professionals. This shows vividly that anti-discrimination work is not just the business of lawyers or journalists – significant as they are – but is centrally important to different communities, government departments and Commissions, private sector agencies and the whole mental health sector.

Crucial aspects of the journey that anti-discrimination champions are on in New Zealand include the vital and increasing consumer leadership of initiatives and the integration of anti-discrimination work into both human rights bodies and mainstream mental health services. These links have the potential to significantly magnify the impact of the more specific anti-discrimination activities, like the successful speakers’ bureaux and advertising campaign.

Across the world people are learning from New Zealand’s experience and will be waiting for information on the next stage of the journey. The more we all understand, from evaluations, which approaches have most effect, the more we shall be able to drive out the discrimination that, for so many consumers, is harder to live with than the original mental health problem. And the closer we shall be to achieving societies that genuinely provide equal citizenship and participation for those amongst us who have a psychiatric diagnosis or history.

Liz Sayce
Disability Rights Commission
United Kingdom
Preface

Journeys Towards Equality describes and analyses all the major work in New Zealand to counter discrimination against people with experience of mental illness. As the size of this report suggests, there is a lot of it going on in many agencies and sectors. Yet most of this work has only started in the last decade.

An initial major development was the amendment of the Human Rights Act in 1994 to include protections for people with disabilities. In the same year the Office of the Health and Disability Commissioner opened. The Mental Health Commission, with its mandate to reduce discrimination, started operating in 1996 and published the Blueprint in 1998. In the same year the Like Minds, Like Mine project began. The Ministry of Health’s 1997 mental health strategy, Moving Forward, included an anti-discrimination objective, although no targets were set. Also in 1997 the national Mental Health Sector Standards created a standard for promoting community acceptance of people with mental illness. And in 2001 the government published the New Zealand Disability Strategy, before setting up the Office for Disability Issues in 2002.

At the time each of these laws, policies, agencies or initiatives was created, it was often without much knowledge of or connection to the others. It is only in hindsight that we can clearly see the synchronicity in their development, their similar values and their complementary activities. This is no accident.

Most of the anti-discrimination work of the last decade was ignited by concurrent and often connected forces in the mental health arena, in other sectors and in wider society. It started as the mad movement was gathering force and the old psychiatric hospitals were closing, and it has continued with the adoption of the recovery approach in mental health services. It has been fed by the disability movement, customer rights, the government’s commitment to social inclusion and human rights and the Māori revival. All these forces, and more, have generated and shaped the anti-discrimination work that is happening today.

Anti-discrimination work in this country may share a common backdrop but this stocktake has found that much of it is happening in isolation. At the moment anti-discrimination work is like a collection of strands that need to be bound into a strong rope through greater leadership and coordination. Leadership ultimately needs to come from the people directly affected by discrimination – those with experience of madness. And it needs to be supported by the major anti-discrimination agencies, which also must ensure that the work is coordinated, effective and responsive to a changing environment.

Journeys Towards Equality provides a benchmark for measuring progress in the anti-discrimination sector. The Mental Health Commission, the Like Minds, Like Mine Project, the Human Rights Commission, the Office for Disability Issues and others will now work together to ensure that progress continues.

Mary O’Hagan
Commissioner
Mental Health Commission
INTRODUCTION

1. Stigma and discrimination are social processes that lead to the exclusion of certain people or groups from their usual and rightful participation in their communities. Social exclusion impacts on participation in employment, leisure, family and community activities, as well as on access to good quality health services and housing. Overall, social exclusion acts to prevent people and groups from social participation and full citizenship.

2. For people who experience mental illness, social exclusion has been endemic throughout New Zealand’s history and remains a key barrier standing in the way of recovery from mental ill health. The 1996 Mason Inquiry into mental health services was sensitive to the harmfulness of social exclusion, highlighting the need to reduce stigma and eliminate discrimination in New Zealand. Two outcomes of this inquiry were the establishment of the Mental Health Commission and the Ministry of Health’s Like Minds Like Mine Project to Counter Stigma and Discrimination Associated with Mental Illness. In New Zealand today the Commission and Like Minds are the most visible face of mental health anti-discrimination activity, but a myriad of other government and non-government organisations and groups have roles and responsibilities in this area. The mental health service user movement has been central to the evolution of the anti-discrimination sector. As its voice has grown stronger, it has increasingly played a leadership role in anti-discrimination projects.

3. This report involves a stocktake of the mental health anti-discrimination sector in New Zealand. We have identified organisations, groups and some individuals engaged in anti-discrimination work and we report on their roles, responsibilities and activities. In this report, though, we have gone further than usual for a stocktake project. We have attempted to identify and critique the theories, explicit and implicit, underlying anti-discrimination work in mental health, for this work rests upon certain assumptions or understandings about mental health and about the processes of social exclusion. Overall, although the activities have similar goals (reduction of stigma and discrimination and the promotion of social inclusion), in practice they differ somewhat, as different philosophies and assumptions underpin them.

4. The main approaches to anti-discrimination in New Zealand today are:
   - **medical model**, focusing on understanding mental illness and reducing stigma and on improving the status of and resources allocated to mental health services. The argument that people with a mental illness should not be stigmatised or discriminated against since they are blameless victims of their illness is promoted by this model.
   - **recovery**, often service user/tangata whaiora-led, focusing on the impact of stigma and discrimination on people with experience of mental illness and viewing these social exclusion processes as causing personal harm, acting as barriers to recovery, discouraging social participation and at times violating human rights;
   - **public health**, focusing on working with communities and whole populations to promote and protect mental health;
   - **whanaungatanga**: Māori approaches to anti-discrimination are influenced by the collectivist value whanaungatanga, which emphasises relationship or kinship. Stigma and discrimination are seen as hurting the whole group, not just the individual;
• *fonofale*: a Pacific model of anti-discrimination. Like Māori models it emphasise community and relationships;

• *human rights*, using legal remedies and educational strategies to emphasise the rights of people with experience of mental illness to autonomy or self-determination;

• *disability inclusion*, emphasising that society has a responsibility to remove barriers to participation experienced by people with disabilities.

5. The type of approach used for anti-discrimination work was, we found, strongly tied to the role of the agency engaged in it. Approaches were not solely ideological, or haphazardly dependent on the knowledge and beliefs of the lead players. Nowhere was this more apparent than in the public sector, which is the dominant location for this work. Consequently, we have located these different approaches in the four sectors of government most involved in anti-discrimination:

• mental health sector (medical model and recovery approaches);

• public health sector (public health, whanaungatanga and fonofale approaches);

• human rights sector (human rights approaches); and

• disability sector (disability inclusion approaches).

These sectors, each with their characteristic approach or approaches, use different kinds of expertise, target different audiences and use different strategies to combat discrimination and stigma and to promote social inclusion.

LIKE MINDS, LIKE MINE: PROJECT TO COUNTER STIGMA AND DISCRIMINATION ASSOCIATED WITH MENTAL ILLNESS

6. The Like Minds project is the cornerstone of anti-discrimination work in New Zealand. Located in the Ministry of Health’s Public Health Directorate, it is led by a National Project Manager. Its National Advisory Group is a group of service users/tangata whaiora from around the country to ensure service user perspectives are incorporated into the project. Like Minds has a two-tier structure, its national programme involving a mass media campaign, as well as other projects; and regional programmes contracted out to local and regional providers, which include public health units and NGOs such as the Mental Health Foundation and the Serious Fun ‘n’ Mind Trust.

7. Overall, the Like Minds project has been a strong force in anti-discrimination activities. It has been well run at a national level and its mass media advertising campaigns have been effective. Located in the public health sector, it has drawn on Ottawa Charter values and mental health promotion approaches, but it has also been strongly influenced by recovery approaches arising from its service user constituency via input from its National Advisory Group, and from its close connection with the Mental Health Commission. Human rights and disability inclusion approaches have also been fostered as the project began to focus more on government policy. The letting of contracts to Māori and Pacific providers has encouraged the development of culturally appropriate anti-discrimination initiatives.

8. Like Minds regional providers – the face of anti-discrimination activities in New Zealand’s communities – have engaged in a wide range of activities. Performance by the providers, as far as it can be judged, has made a considerable impact, and providers have ranged from inspirational to (on occasion) poor.

9. The location of the Like Minds project in public health has been one key to its success, in that it has been able to summon up the resources and expertise to conduct a very effective mass media campaign. The structure of the public health sector also helped with organising, and in some
cases delivering, the regional activities. But as the project moves forward into more directly tackling discrimination (as opposed to stigma), it could benefit from a closer alignment with service user organisations as well as with the disability, mental health and human rights sectors.

CENTRAL GOVERNMENT

10. Government’s role in mental health anti-discrimination activities is far-reaching. The ways in which government furthers anti-discrimination includes devising and implementing laws, strategies and policies; implementing anti-discrimination measures in its workplaces; promoting anti-discrimination in mental health services; providing direction via the Mental Health Commission; delivering anti-discrimination programmes to the public via Like Minds and public education settings; and offering remedies for discrimination through sources as varied as the Health and Disability Commissioner and the Office of Film and Literature Classification.

Mental health sector

11. The key central government agencies in the mental health sector are the Ministry of Health and Mental Health Commission.

12. The Ministry of Health, through its Mental Health Directorate, prepares national strategic plans, which include anti-discrimination objectives. With Standards New Zealand, the Ministry develops performance standards, which include Standard 18, the anti-discrimination standard that applies to all government-funded mental health services.

13. One area of potential conflict with rights-based approaches to anti-discrimination activities is that the Ministry develops and administers mental health legislation authorising compulsion against service users in certain circumstances.

14. In its approach to anti-discrimination work, the Directorate blends a medical model, emphasising that stigma and discrimination prevent access to mental health services and impede good service delivery, with recovery approaches, their emphasis enabling community acceptance and social inclusion for mental health service users. Through its involvement with the Like Minds project, the Ministry also frames some of its activities within public health models.

15. The Mental Health Commission has three statutory functions:
   • to monitor and report to the Government on the performance of the Ministry of Health in the implementation of the Government’s National Mental Health Strategy
   • to strengthen the mental health workforce
   • to work with the sector to promote better understanding by the public of mental illness, reduce stigma and eliminate discrimination.

16. These functions all contribute to anti-discrimination objectives in some way. The strong emphasis on anti-discrimination work in its legislation is a direct result of the emphasis given it by the Mason Inquiry. Overall, the Commission’s role in the mental health sector involves providing leadership through monitoring and innovation. It is the only central agency with a statutory requirement to conduct anti-discrimination work in the mental health sector. The Commission has carried out its anti-discrimination work in a number of ways, including projects, publications, sector monitoring and events. A formal examination of the Commission’s anti-discrimination work showed it is working within a recovery philosophy, as well as embracing aspects of the human rights and disability inclusion approaches.

Public health sector

17. The Public Health Directorate within the Ministry of Health is where the Like Minds project is based (although the project also receives funding from the Mental Health Directorate). Overall, public health brings to mental health anti-discrimination initiatives a wide scope, focusing as it does on the health and resourcefulness of whole populations. It can also focus on populations at risk, including people with experience of mental illness. Public health has adopted the international standards embodied in the Ottawa Charter for Health Promotion. Its mental health promotion strategy, Building on Strengths, acknowledges the importance of the contribution that people with experience of mental illness have to make in prevention and promotion endeavours, and emphasises that people with experience of mental illness are a population group who should receive
health promotion interventions. The importance of working against discrimination is also emphasised.

18. Māori models of health and mental health, such as Te Whare Tapa Wha and Te Pae Mahutonga, are the basis of anti-discrimination work in Māori and Pacific communities. These models sit well within public health because they are holistic, incorporating family and community dimensions. The individual is not to be separated from a wider family network and stigma and discrimination are seen to affect whole communities. This emphasis can be referred to as whanaugatanga (relationship or kinship), which is the term we have given to Māori approaches to anti-discrimination. Within Te Puawaitanga: Māori Mental Health National Strategic Framework, one of the strategic objectives is to ensure links with the Like Minds project.

19. Fonofale is a Pacific model of mental health used in anti-discrimination activities. The Pacific Health and Disability Action Plan sought to improve Pacific mental health status through promotion and prevention activities, which by their nature imply anti-discrimination initiatives.

Human rights sector

20. The human rights emphasis in mental health anti-discrimination activities is driven by three agencies: the Ministry of Justice, the Human Rights Commission and the Office of the Health and Disability Commissioner. These agencies have complementary roles: the Ministry of Justice develops and implements policy and law (for example, human rights legislation and the New Zealand Bill of Rights Act 1990); the Human Rights Commission promotes human rights and harmonious relations between diverse groups in New Zealand society and attempts to protect New Zealanders from unlawful discrimination; and the Office of the Health and Disability Commissioner works to promote and protect the rights of health and disability service consumers. An additional agency, the Office of the Ombudsman is an ‘office of last resort’ for dealing with complaints.

21. The Human Rights Commission has a central position in the mental health anti-discrimination environment, with its roles and functions set out in the Human Rights Act 1993. In 1994 discrimination based on disability, defined to include ‘psychiatric illness’, ‘psychological disability or impairment’ and ‘any other loss or abnormality of psychological, physiological, or anatomical structure or function’, was deemed unlawful. The Human Rights Amendment Act 2001 expanded compliance with the Act to all government agencies and public bodies. Breaches of the Human Rights Act occur when a person is discriminated against in:

- employment
- access to education
- access to public places, vehicles and facilities
- provision of goods and services
- land, housing and accommodation
- industrial and profession associations, qualifying bodies and vocational training bodies
- partnerships.

22. The Human Rights Commission has a role in mediating disputes, but no longer investigates disputes or forms opinions about whether a complaint under the Human Rights Act has substance. Only a small proportion of complaints concern discrimination on the basis of psychiatric disability. There is a separate Office of Human Rights Proceedings and the Director of that office may take a dispute to the Human Rights Review Tribunal, which has the power of a court with legally binding decisions. To date, there have been no mental health cases presented to the Human Rights Review Tribunal.

23. If the Human Rights Review Tribunal finds a government agency or public body has discriminated that body may be subject to the same penalties as any citizen (that is, a restraining order, an apology, damages or other compensation). When discrimination is mandated by legislation, the Tribunal may make a Declaration of Inconsistency, which must be reported to Parliament, so the decision whether to change legislation or confirm its intention to discriminate falls back to the democratic process. The Tribunal has not yet made such a declaration relating to mental health discrimination.

24. The Human Rights Commission maintains oversight of New Zealand’s compliance with international instruments on human rights. Five such instruments relate to mental health, though some are non-binding.
25. The Human Rights Commission is currently developing a New Zealand Action Plan for Human Rights. Also, it engages in human rights promotion and education, including training in rights for people with disabilities.

26. The Office of the Health and Disability Commissioner promotes and protects the rights of health and disability service users. The Code of Health and Disability Services Consumers’ Rights covers the broad principles that should govern the delivery of all health and disability services. Complaints can be investigated by the Office and can often be resolved with the assistance of advocates. In terms of anti-discrimination in mental health, the Commissioner is constrained by the Mental Health (Compulsory Assessment and Treatment) Act 1992.

27. The Ombudsmen’s Office is an ‘office of last resort’ for dealing with complaints about central or local government organisations, including complaints of discrimination. This office can provide information on the many specialist review authorities set up to deal with complaints in different areas of public life, both within and outside the Ombudsmen’s jurisdiction.

**Disability sector**

28. The key government player in the disability sector in relation to anti-discrimination activities is the Office for Disability Issues. It was established in July 2002 as a semi-autonomous agency administered by the Ministry of Social Development’s Sector Policy Group. It monitors the implementation of the New Zealand Disability Strategy, provides policy advice on disability issues, and supports the Minister for Disability Issues. The Strategy provides a long-term plan for removing the barriers that prevent disabled people from full participation in their communities. The Office’s driving philosophy is one of disability inclusion in a society that, intentionally or unintentionally, discriminates against people with impairments. Mental illness is brought into the disability framework when the ‘impairment’ of mental illness is seen to limit a person’s full potential through society’s lack of understanding. The Office undertakes a number of general anti-discrimination activities targeting disability sector issues, including those affecting people with mental illness.

**Other government agencies**

29. Government agencies other than those with central responsibility for mental health, public health, human rights and disability also play important roles in anti-discrimination work. Their initiatives range from employment assistance programmes to suicide prevention to curriculum development on mental health. Many of the initiatives are fundamentally informed by the New Zealand Disability Strategy. Our stocktake does not provide a comprehensive examination of the work of all government departments; instead, we examined several programmes of activity.

30. The State Services Commission takes on a public service leadership role through its leadership in equal employment opportunities (EEO) and its administration of the Mainstream Programme, which facilitates employment opportunities in the state sector for people with significant disabilities.

31. In 2001 the Ministry of Youth Affairs took responsibility for leading and co-ordinating the New Zealand Youth Suicide Prevention Strategy. The strategy includes the goal of fostering initiatives to reduce the stigma of mental illness, given the relationship between suicide and mental illness.

32. Department of Work and Income produced *Pathways to Inclusion: Nga ara whakauru ki te iwi whanui: Improving vocational services for people with disabilities*. This review of vocational services includes initiatives such as the repeal of the Disabled Persons Employment Promotions Act 1960, which exempts employers of people with disabilities in sheltered workplaces from minimum wage and holidays legislation.

33. Health promotion, including mental health promotion, is one of the underlying concepts of health and physical education in the New Zealand education curriculum, directed by the Ministry of Education.

34. Creative New Zealand (Arts Council of New Zealand Toi Aotearoa) is the major source of arts funding in New Zealand. One of its functions is to ‘encourage, promote, and support the arts … of the diverse cultures of New Zealand’. Funding is given to Arts Access Aotearoa. There is debate
around the idea that cultural diversity does not imply only ethnic diversity, but may refer to other communities of interest. Potentially this could be interpreted to include communities identifying around the experience of mental illness.

35. The Office of Film and Literature Classification is governed by the Films, Videos and Publications Classification Act 1993. Publications (which includes films, videos, computer games and sound recordings) can be prohibited or restricted if they are deemed ‘objectionable’, that is, ‘likely to be injurious to the public good’. A publication that represents people with psychiatric illness as ‘inherently inferior to other members of the public’ does have the potential to be judged objectionable. Although this is a provision that has seldom been used in relation to any disadvantaged group, one successful complaint resulted in raising the age restriction of a film regarded as conveying discriminatory attitudes towards schizophrenia.

NATIONAL PROFESSIONAL AND MENTAL HEALTH NON-GOVERNMENTAL ORGANISATIONS

Professional organisations

36. Professional organisations whose members work in the mental health sector, such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and the New Zealand Psychological Society do not yet take any significant role in the New Zealand anti-discrimination sector. Professional bodies emphasise professional support and development to members and the development of competencies for good clinical practice. They also sometimes turn their attention to wider health and social issues, and it is in this context that professional bodies in some other countries, such as the United Kingdom and the United States, have been involved in anti-discrimination.

National mental health non-governmental organisations

37. National NGOs have wide coverage and focus on a broad range of issues. They can coordinate, promote, educate, advocate and/or provide services that assist mental health service users. Few national NGOs organise their activities around anti-discrimination, but many contribute to anti-discrimination and destigmatisation in the course of their work. The Mental Health Foundation, for example, has mental health promotion as its main focus. In relation to anti-discrimination, the Foundation tends not to initiate specific projects on its own account, but it is a major provider to the Like Minds project, with involvement in projects that include the government policy project and Speakers’ Bureau. Platform is a national organisation that gives a voice to mental health sector NGO organisations providing community services. It has provided support to anti-discrimination initiatives through a number of its projects, including Standards in Action, which involves assisting its members to implement the mental health standards.

38. Some national organisations focus on particular mental illnesses. Schizophrenia Fellowship’s charter includes a call for action "to end stigma and discrimination against people with a mental illness, through improved education of the general community and health professionals, legislation and more accurate and responsible representation in print and electronic media". Balance, a national bipolar and depression network established and operated by service users to help members with mood disorder, uses a recovery framework. Peer support processes are particularly effective at combating internalised stigma.

39. There is at present no national body representing service user organisations. Efforts have been made over the last few years to develop regional networks and a national network. When these have developed there is likely to be a strong impact on the leadership and direction of anti-discrimination work, because anti-discrimination activities are core business for service user groups.
REGIONAL AND LOCAL PROVIDERS

Mental health service providers
40. All publicly funded mental health service providers at the local level, whether DHB services or NGOs, need to meet Human Rights Act anti-discrimination obligations, just as central government does. They are also required to meet Standard 18 of the National Mental Health Standards. Four broad types of anti-discrimination activity may be integrated into mainstream service delivery, often informally: work with mental health service users; work with critical gatekeepers inside the mental health sector; work with those who govern access to other sectors (housing, employment, government services and education); and promoting non-discriminatory practices, attitudes and behaviours in the broader community.

District Health Board mental health services
41. District Health Boards are the major providers of specialised mental health services in New Zealand. It was not possible to survey all the activities of all DHBs, so a few select examples are given to demonstrate the kinds of activity that are undertaken. The continuous quality improvement emphasis of the Mental Health Standards lays the basis for the evaluation of anti-discrimination initiatives and working towards improvements over time. However, the Standards in practice do tend to emphasise meeting policy requirements rather than measuring activities and their outcomes. It was the view of some of the interviewees for this project that mental health services were not integrating anti-discrimination approaches into their everyday practices as well as they might, nor were they carrying out enough in the way of focused activities.

42. It was also pointed out that mental health services often carry out their anti-discrimination work largely within the medical model. However, anti-discrimination work should operate more widely across recovery, human rights, public health and other models (in fact Standard 18 has a strong human rights, public health and disability inclusion emphasis).

Regional NGOs providing mental health services
43. NGOs funded with mental health money (whether through a DHB or otherwise) to deliver services, such as primary or secondary mental health care, residential care, community support or employment services are required to meet the National Mental Health Standards which, as mentioned, have an anti-discrimination component. There are several NGOs that engage in anti-discrimination work as part of their day-to-day activities, such as employment support providers. These NGOs tend not to be funded specifically to conduct this activity but do so as part of working with the wider community.

Service user organisations
44. Service user organisations, including some regional networks, conduct specific anti-discrimination activities. Anti-discrimination is generally considered a defining activity for most service user organisations, whether it is funded or not. The politics of identity is used by many consumer groups to locate themselves and the activities they engage in. Work often focuses on dealing with direct discrimination through activism and education, as well as internalised stigma through peer support. More support could be offered to service user organisations for service development and possible transition to fully funded providers. The emergence of national networks of service user groups will make an impact in the future.

Regional public health units
45. Regional public health units have a focus on health promotion, developing initiatives to mitigate a range of public health issues such as sexual health, smoking, tuberculosis and mental health. In relation to mental health promotion, this has led to regional projects that deal directly with anti-discrimination issues. A number of regional public health units hold Like Minds contracts but these do not cover all their anti-discrimination work. Training of the public health workforce in anti-discrimination work is an issue that needs addressing, as health promotion training does not necessarily cover this.
RESEARCH, ARTS AND CULTURE AND THE PRIVATE SECTOR

46. Research, local and international, has the potential to contribute to anti-discrimination work by: identifying the social and psychological processes involved in stigma and discrimination; documenting and analysing the ways in which stigma and discrimination operate in society; and researching effective techniques to combat stigma and discrimination.

47. Research funding is usually contestable and awarded on the basis of excellence, although funding bodies may set overarching goals and priorities that may encourage anti-discrimination research. Potential New Zealand sources of research funding are the Health Research Council and the Mental Health Research and Development Strategy. Mental health sector organisations involved in anti-discrimination activities, such as the Ministry of Health, the Mental Health Commission and mental health providers have some capacity to conduct or contract research on stigma and discrimination. Like Minds also has an active research programme focused largely on evaluation, but extending more broadly on occasion.

48. There has been a surprising amount of research on stigma and discrimination in New Zealand, considering its size. Research has included attitude surveys, discourse analysis of media representations of mental illness, research on the experience of stigma, and evaluations of the effectiveness of various approaches. Given the innovative nature of Like Minds and the strong investment from government in removing discrimination, further research should be encouraged.

49. Representations of mental illness in books, films, television and other media are often negative, drawing on inaccurate stereotypes and promoting incorrect associations between mental illness and dangerousness. Arts and cultural activities, therefore, have the potential to increase discrimination, but can also produce anti-discrimination messages that can have enormous impact. Disability culture, as a social movement, is currently emphasising identity through art that positively affirms pride and diversity. Also, individual artists, writers and others have often produced work challenging stereotypes and increasing understanding. Harnessing the power and immediacy of arts and culture for anti-discrimination work is not always easy, but this is a pathway that should not be overlooked.

50. Some pharmaceutical companies involve themselves in public education strategies that may include anti-stigma messages. Their medical model approach may sit uneasily with other approaches to anti-discrimination and their materials are likely to emphasise the utility of their particular medications, but these particular companies have also provided some useful recovery and anti-stigma information.

CONCLUSIONS

51. After all that has happened since the mid-90s it now makes sense to talk about a sector engaged in mental health anti-discrimination activities. Here we summarise our findings about this sector, shaped around our initial questions:

**Who is undertaking the work of mental health anti-discrimination?** The wide range of organisations responsible for and involved in anti-discrimination surprised us.

**What are their roles and obligations?** This, too was diverse. Organisations carry out mental health anti-discrimination work for a variety of reasons, ranging from legislative obligations to passionate commitment.

**What is their approach to anti-discrimination work?** We identified a number of different philosophies of anti-discrimination (described in the introduction), as well as differing focus, in relation to the processes of stigma and discrimination (described in Appendix 1). We concluded that by understanding the range of approaches and the sectors they live in, organisations should achieve a better understanding of their own work and how effective it might be. Also, they should become able to engage more usefully in networking and collaboration.

**What kinds of anti-discrimination activities are they undertaking?** Anti-discrimination activities include legislation, complaints resolution, service standards and monitoring, EEO programmes in workplaces, mass media campaigns, activities engaging with the media, workshops and other learning situations, protests, publications, story-telling, arts and culture
activities, research – the list goes on. As well as
the formal programmes, anti-discrimination
activities occur in a myriad of ways at the
informal level through social interactions among
and between service users/tangata whaiora,
service providers, families and whanau, agencies
and the general public.

Are they meeting their obligations? National
organisations with statutory obligations and/or
obligations in terms of their charters and
constitutions, are mostly meeting their
obligations, although of course more could be
done. More coordination and support for national
NGOs, especially those with strong service user
involvement, could result in increased impact
and effectiveness. Professional associations need
do more work in this field. Most importantly –
in our view – providers of mental health services
should do considerably better as a sector. Mental
health services have tremendous opportunities,
both through everyday work and special
programmes, to combat stigma and
discrimination, and we would like to see them all
involved in this task in a lively and committed
way.

Is their work making a difference? Impact and
effectiveness are hard to measure, but national
surveys for Like Minds tell us that stigmatising
and discriminatory attitudes across the whole
population are decreasing. More work needs to
be done on the effectiveness of particular
providers and particular interventions. Workforce
development is a key issue in relation to ‘making
a difference’, as the anti-discrimination workforce
has evolved informally and the indications are
that there are considerable training and
development needs before it becomes a solid,
effective workforce.

Are they working well alongside others in the
field? An increasing level of cooperation around
anti-discrimination work has developed at central
government level. There is more room for
cooperation at the national level with the NGO
sector and professional bodies. The strengthening
of service user input at the national level should
be a priority. And at the local level, there is room
for more support for service user-led groups and
increased coordination between Like Minds
providers and mental health service providers,
each responsible for anti-discrimination work in
their own ways.

Are there gaps in the sector? New Zealand has
the infrastructure within central government to
attend effectively to stigma and discrimination,
although organisations taking a lead (Mental
Health Commission and Like Minds) are not
permanent structures. Issues around coverage
have already been canvassed. In terms of
particular population groups and communities of
interest, programmes have been developed
specifically by and for Māori and Pacific
communities, but attention has only recently
been given to Asian communities. In terms of age
groups, Like Minds targets young and mid-adult
populations, not older adults. Not much has
been done to think through how particular
communities of interest might deal with stigma
and discrimination.

FUTURE NEEDS OF THE SECTOR

Having discovered the wealth of anti-discrimination
work currently being undertaken in New Zealand and
examined the philosophical underpinnings and sector
locations of anti-discrimination work, the future needs
of the sector have become more apparent. As a result
of this stocktake the Mental Health Commission and
Like Minds will be facilitating work across key
agencies and organisations to look at the future of the
sector. Service user leadership in this work will be
key, as “nothing about us without us” must be a
central principle of anti-discrimination work. It is our
intention to produce an Action Plan that will provide
some guidance around the structures that are required
to ensure that the good work that has been done so far
is continued.
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One of the most painful, widely felt, and insidious problems for people who experience mental illness is social exclusion. The direct effects of mental illness may contribute to social exclusion in some cases and at some times, but the major contributor is discrimination. (Mental Health Commission 1998b: 2)

There is no doubt that the feeling of alienation created by stigma is one of the significant reasons cited for loss of hope and relapse by those who experience mental illness. (Mason 1996: 163)

Stigma and discrimination are social processes that lead to the exclusion of certain people or groups from their usual and rightful participation in all kinds of social activities and enterprises. Social exclusion impacts on participation in employment, leisure, family and community activities, as well as on access to good quality health services and housing. It is contrary to social justice in that it acts to prevent people and groups from full social participation and full citizenship.

In relation to people who experience mental illness, social exclusion has been a feature of New Zealand society since colonial times when the first ‘lunatic asylums’ were founded. ‘Out of sight, out of mind’ was the prevailing mental health ethos until the large institutions began closing in the 1970s. After that time psychiatric units for the treatment of acute illness were established in public hospitals and mental health services came to be provided to people in their communities.

Social exclusion is not just about physically separating people away into institutions. Stigma and discrimination result in social exclusion within our communities, depriving people with experience of mental illness of social opportunities and acting as a barrier to recovery. The 1996 Mason Report, arising from a ground-breaking inquiry into mental health services, pointed to stigma as a major problem to be addressed. The report argued that public attitudes should change:

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 1996: 164)

The Mason Inquiry recommended the establishment of a Mental Health Commission, and the Commission was set up shortly afterwards. Key functions, embodied in its establishing legislation, include the tasks of reducing stigma and eliminating discrimination associated with mental illness. The Inquiry also led to the establishment of a national anti-discrimination project, now known as ‘Like Minds, Like Mine: Project to Counter Stigma and Discrimination Associated with Mental Illness/Whakaitia te Whakawhiu i te Tangata’ (referred to as Like Minds throughout this report). This is a Ministry of Health initiative began in 1999 and is the major and most visible player in mental health anti-discrimination and destigmatisation activities in New Zealand.

The Mental Health Commission and Like Minds are far from the only organisations in New Zealand involved with anti-discrimination activities. Many other organisations, agencies and individuals in the public, non-governmental organisation (NGO) and
private sectors, and within and outside the health sector, are involved. Since the Mason Inquiry there has been considerable growth in the anti-discrimination work being undertaken right across the board, responding to a variety of drivers that include the service user movement, human rights legislation, mental health standards and government policy directions.

WHY A STOCKTAKE?

Taking Stock is the Mental Health Commission’s investigation into the diverse range of activities that comprise mental health anti-discrimination and destigmatisation work in New Zealand. Our report identifies the key agencies, their roles, obligations and activities, as well as examining how anti-discrimination activities fit into the work of agencies and sectors that can make a more minor, but still important contribution.

Earlier in the Commission’s life we published A Travel Guide for People on the Journeys Towards Equality, Respect and Rights for People Who Experience Mental Illness with its associated poster, Map of the Journeys (Mental Health Commission 1998b). That project, led by people with experience of mental illness, was a bold attempt to set directions for work in this field.

The Travel Guide outlined seven destinations:

– A country in which people with mental illness have the personal power to gain equality, respect and rights
– A health sector which values people with mental illness and treats them fairly
– Laws and practice upholding the rights of people with mental illness
– Public organisations which are accessible and fair for people with mental illness
– Private organisations which are accessible and fair to people with mental illness
– Communities which behave fairly and inclusively towards people with mental illness
– E Aro ki te Ha o te Tangata [The pathway of life for people]

Pathways were drawn up, outlining ways to eliminate discrimination on the route to each destination.

Our Taking Stock project is a look at what use has been made of those pathways and how far New Zealanders have travelled on those journeys. By outlining the roles, responsibilities and legislative obligations of various agencies, we hope to encourage the fulfilment of obligations. By describing the range and kinds of anti-discrimination activities that occur in New Zealand, we hope that everyone engaged in anti-discrimination (as well as those who ought to be engaged) will better understand their place in the broader picture, so that they can work together appropriately.

Our stocktake goes further than merely describing the anti-discrimination roles and activities of various agencies. It takes an analytical approach, as well. We have tried to identify and comment on the theories, explicit and implicit, that underlie anti-discrimination work in mental health. All attempts to promote changes in society rest on some kind of theory about how the world works. Well-founded and useful theories should lead to effective change strategies, but because the world is a complex place, attempts to change it are tricky. Some change strategies work only for some populations or individuals, some are politically unacceptable because they clash with overriding policy directions, some have unintended consequences, and some even make the original problem worse. Often, it is hard to know which strategies are working and which are not, although indicators and evaluation research can help with these questions.

Anti-discrimination work in mental health rests upon certain assumptions or understandings about mental health, as well as about the processes of social exclusion. Although anti-discrimination activities have similar goals (reduction of stigma and discrimination and promotion of social inclusion), in practice they often proceed differently, deriving their course of action from distinctive philosophies and assumptions underpinning them. At worst, some even lose sight of their goals. To understand what underlies the work is to allow discussion and critique of its direction. This kind of reflection also helps us to realise why some agencies will want to proceed differently from others, and where pooling of resources will be helpful.

In summary, this stocktake asks basic questions about anti-discrimination in mental health: Who is undertaking the work? What are their roles and obligations? What kinds of anti-discrimination activities are they undertaking? What is their approach to anti-discrimination work? Are they meeting their obligations? Is their work making a difference? Are they working well alongside others in the field? Are there gaps in the sector?
DISCRIMINATION AND STIGMA IN MENTAL HEALTH

There has been some debate in the mental health sector about whether it is more worthwhile to focus on discrimination or stigma in anti-discrimination efforts. Interestingly, our Travel Guide strongly encouraged the sector to focus on ending discrimination rather than reducing stigma (Mental Health Commission 1998b).

A dictionary definition of ‘discrimination’ is ‘unfavourable treatment based on prejudice’ (Oxford English Reference Dictionary 1996). According to the Human Rights Commission, discrimination ‘occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances’ (Human Rights Commission 1993). The Human Rights Act 1993 provides for various grounds on which it is unlawful to discriminate. One ground is disability, including psychiatric disability.

A dictionary definition of ‘stigma’ is ‘a mark or sign of disgrace or discredit’ (Oxford English Reference Dictionary 1996). In sociological terms, it is ‘a deeply discrediting attribute’ (Goffman 1963). So stigma involves prejudice against people who are thought to experience mental illness.

Focusing on stigma, so the argument in the Travel Guide goes, draws attention to people who experience mental illness or are associated with it, as if the associated prejudice were their problem. Discrimination, on the other hand, locates the problem within society and shifts the focus towards the people who perpetuate prejudice, knowingly or unknowingly.

In this report we investigate both anti-discrimination and destigmatisation activities; in fact, for many activities it is impossible to separate them. However, we try to identify the ways in which different approaches lend themselves to different emphases in relation to discrimination or stigma.

To avoid overly cumbersome terminology, we use the term ‘anti-discrimination activity’ in a general way in this report to include work on stigma as well as discrimination. When we wish to make a distinction between the two concepts we do so explicitly. (For a more detailed explanation of the processes involved in stigma, discrimination and social exclusion, see Appendix A.)

WHO IS THIS REPORT FOR?

We intend this report to be useful for managers of mental health anti-discrimination projects, policy analysts and advisors involved in developing anti-discrimination policy, people who ‘do’ anti-discrimination work, people who work in and use mental health services and people who are generally interested in anti-discrimination work.

Each group may find this report useful for a different reason. Policy people and managers may be interested in learning about what various agencies do or plan to do, and how their own work fits across different sectors (for example, the health, education and wider social sectors). For people who are new to, or generally interested in, anti-discrimination work, this report provides a useful overview of anti-discrimination activity and identifies new ways of thinking about it. It also provides an historical context for the activity and shows how it is organised and how different people and organisations carry it out.

Understanding agencies’ different approaches to anti-discrimination activity, the sector imperatives affecting them and the theories they rest on, helps us to communicate across agencies.

METHODS: HOW WE WENT ABOUT THE STOCKTAKE

The development process for this report involved a range of work conducted from 2002 to 2004 (see Appendix B for more details).

First, the Commission developed an Anti-Discrimination Framework (discussed further in Appendix B), which was designed to help plan, assess and evaluate anti-discrimination activities. The framework was tested and modified after being assessed against the Commission’s anti-discrimination work programme. It will be published separately as a tool for the sector.

A second project involved key people who undertake mental health anti-discrimination activities being interviewed (see Appendix C for the people interviewed).

A third project focused on agencies’ obligations, objectives and work programmes. The agencies selected were key players in anti-discrimination work and/or represented the diversity of activity that falls into the category of anti-discrimination work.
Documents were gathered from web sites, the Mental Health Commission library, and key agencies. The anti-discrimination work mentioned in the documents was analysed using the framework as a guide. Drafts of the subsequent report were sent to all the agencies involved and their feedback was invited.

ANTI-DISCRIMINATION APPROACHES

Our analysis of the philosophies and approaches underlying anti-discrimination activities has been a core part of the stocktake. We have been influenced in this analysis by Liz Sayce and her influential work *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (2000), as well as by an investigation by Hamish MacKenzie (2002), carried out specifically for this project. However, as we examined the work of the various agencies we found that we needed to alter the various categories of anti-discrimination activity that they had proposed.

We find it useful to think of the agencies doing anti-discrimination work as mainly belonging to one of four different sectors: mental health, public health, human rights and disability (see Figure 1).

Each sector has a characteristic way of thinking about and undertaking mental health anti-discrimination activities (an approach, or a paradigm or a philosophy, to use terms which are interchangeable here). These approaches are placed below the sectors. The human rights and disability sectors are each dominated by one main approach to anti-discrimination work (human rights and disability inclusion), but in mental health the medical model and the recovery approach are both to be found, arising from quite different perspectives. Public health sector mental health anti-discrimination activities are largely driven by the mental health promotion approach, and indigenous models (Māori and Pacific ways of doing anti-discrimination) seem to relate more closely to public health than to other models.

In what follows we explore the paradigms associated with the different sectors in more detail, pointing to some of their strengths and weaknesses. It should be emphasised that since anti-discrimination work in mental health is fairly new and has been a growth area in the last decade, the paradigms that we describe are emerging and often are not named or recognised by people who work within them. Also, paradigms are not ‘real’ or ‘pure’, they are just ways of describing the

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**Figure 1. Sector approaches to anti-discrimination activities in mental health**
work that we do and the affiliations we have. Actual anti-discrimination work will often draw on aspects of more than one paradigm; for example the recovery approach draws strongly on human rights and disability inclusion approaches. Overall, we believe that by naming and describing these approaches, we make it easier for critical discussion about anti-discrimination work to occur.

**Mental health sector**

The mental health sector weaves anti-discrimination efforts into its broader aims of achieving better mental health services and a better quality of life for mental health service users. Medical model and recovery approaches are paradigms within the whole field of mental health, not just for anti-discrimination work; but as might be expected, they encourage different approaches to anti-discrimination.

**Medical model**

The medical model gives rise to anti-discrimination work focusing on understanding mental illness and reducing stigma and on improving the status of and resources allocated to mental health services.

The medical model argues that people with a mental illness should not be stigmatised or discriminated against since they are blameless victims of their illness, just like people with a physical illness. Biological foundations of mental illness are emphasised in this approach, which often sees educating the public about mental illness as a key strategy.

Mental health organisations in other countries, such as the National Alliance for the Mentally Ill (NAMI) in the USA and SANE in Australia, have often based their campaigns on the medical model. NAMI states that its ‘education programs and information publications offer opportunities to learn more about brain disorders and mental health issues’ ([www.nami-eastside.org/education/education.htm](http://www.nami-eastside.org/education/education.htm)); while SANE provides information on various mental illnesses such as schizophrenia, which is seen as ‘a medical condition [that] affects the normal functioning of the brain’ ([http://www.sane.org/](http://www.sane.org/)).

Associations of mental health professionals and drug companies draw on this model when they engage in public education to reduce stigma, which they see as acting as a barrier to people seeking help. Much mental illness, it is argued, goes needlessly untreated and interventions could be more successful if they were made earlier in the course of illness. Stigma is also viewed as a barrier to funding and prestige for mental health services.

This model has drawn some criticism from proponents of other approaches. In New Zealand a series of research studies from John Read and colleagues suggests that people who believe mental illnesses are biologically caused are likely to retain stigmatising attitudes. Viewing ‘mental illness as just an illness’ is associated with the stigmatising belief that people with mental illness are dangerous and unpredictable (Read 2002; Read and Harre 2001; Read and Law 1999; Walker and Read 2002).

The medical model may also inadvertently increase stigma and discrimination if it presents the experience of mental illness as having no value because it results from biological disorder.

**Recovery approach**

The recovery approach, with its origins in mental health consumer movements, has a broader scope. This ‘whole of life’ approach focuses on the impact of stigma and discrimination on people with experience of mental illness and viewing these social exclusion processes as causing personal harm, acting as barriers to recovery, discouraging social participation and at times violating human rights.

The Commission’s *Blueprint for Mental Health Services in New Zealand* introduced the recovery approach into New Zealand’s mental health policy ([Mental Health Commission, 1998a](#)); and the *Travel Guide* spelled out the implications of a recovery approach for anti-discrimination work.

Within this recovery approach, people with experience of mental illness are seen as having the capacity to recover from illness or to live well with illness. In anti-discrimination terms, they should not be prevented from doing so by people and systems that have no hope or belief in them. *Kia Mauri Tau!* *Narratives of Recovery from Disabling Mental Health Problems*, a bicultural research project analysing 40 people’s experiences of recovery, showed how ‘whole of life’ (employment, relationships, where you live, and so on) rather than just mental health intervention is important to recovery. The report showed stigma to be the most significant barrier to recovery. (Lapsley, Nikora and Black 2002).

The recovery approach has its roots, internationally, in the mental health consumer movement, which plays a major role in anti-discrimination work in New Zealand.
Zealand. Understanding stigma and discrimination has developed from a focus on individual experience, and using personal experience has been a key strategy in anti-discrimination efforts. Presenting individuals' stories of mental illness through such vehicles as television documentaries and Speakers Bureau events can make an emotional impact on viewers and listeners. This approach also involves an analysis of the politics of mental health and is sensitive to differentials in power and the ways in which stigma and discrimination can be found within mental health services.

As a way of framing anti-discrimination work, the recovery approach has some internal tensions. It argues that the medical model of stigma reduction, by focusing on the context of medical illness and health service provision (eg, seeing stigma as a barrier to service uptake), is too limited. By focusing on individuals' stories set in their wider life context, the recovery approach enables a deeper understanding of the experience of stigma and its impact on the recovery of individuals. However, despite the powerful understandings of stigma that the recovery approach generates, there has been advocacy for a focus away from stigma and onto discrimination. We have already mentioned the argument in the Travel Guide that focusing on stigma draws attention to the person experiencing discrimination rather than to those who are discriminating. The recovery approach, with its ‘whole of life’ emphasis, naturally lends itself to a focus on human rights and social inclusion, and is a good corrective to the medical model, but we suggest that its potential strengths for addressing stigma should not be underestimated.

**Public health sector**

Public health sector strategies have a wide scope, focusing on working with communities and whole populations to promote and protect mental health.

**Mental health promotion**

In New Zealand public health and health promotion core principles draw on the Treaty of Waitangi and the Ottawa Charter for Health Promotion (WHO 1986). In relation to mental health, public health approaches aim to improve New Zealanders’ mental health by enhancing individual resiliency, strengthening communities and building healthy public policy.

Public health, with its roots in illness prevention, has been heavily influenced by the medical model of disease, but in mental health it now often takes a more holistic approach, incorporating different cultural approaches and (to some extent) recovery ideas.

Public health anti-discrimination efforts tend to convey the message that people with a mental illness are not very different from other people because people all share a common humanity, and this includes our experiences of distress and mental health problems which differ only in degree. Like Minds television advertisements, featuring famous and successful people with a mental illness, exemplify this approach. They ended with the slogan: ‘One in five people experience mental illness at some time in their lives.’

One criticism of this ‘common humanity’ approach is that in its attempt to minimise the differences between people with mental illness and others, it tends to focus on the less severe spectrum of mental disorder and may inadvertently increase stigma and discrimination against people who are most severely affected by their mental illness and who are often perceived as being the most different.

Locating anti-discrimination work in public health units that primarily perform promotion and prevention work may cause conflict, because anti-discrimination work has not always featured in mental health promotion models. The rationale has been that since people who experience mental illness are, by definition, already ill, they are not amenable to prevention efforts (which should target healthy and at-risk populations). However, increasingly anti-discrimination work is finding its way into the public health models. For example, New Zealand’s mental health promotion strategy identifies people affected by mental illness as a priority population group for targeting mental health promotion efforts, and sees anti-discrimination work as a key element in this (Ministry of Health 2002a). Nevertheless, people who have been educated in mental health promotion may not have had any training around anti-discrimination.

Cultural or indigenous models of anti-discrimination seem to fit best within public health approaches, as they tend to focus on the health of population groups rather than on individuals. Here we discuss emerging Māori and Pacific approaches to anti-discrimination, whanaungatanga and fonofale.

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1 The Ottawa Charter, an international charter, has been widely adopted into the goals of public health agencies around the world.
Whanaungatanga
In New Zealand, public health plans and strategies have attempted to incorporate Māori perspectives about health and well-being. Māori approaches to anti-discrimination, largely emerging via the Like Minds project, seem to be influenced by the collectivist value whanaungatanga, which refers to relationship or kinship, where everyone within the whānau has a role and position. Within this value, stigma and discrimination are seen as not just hurting the individual; they hurt the whole group to which the individual belongs because the individual is subsumed within that group – the ‘I’ is ‘we’. This is often relevant for people from indigenous non-Western cultures.

Work promoting whanaungatanga would aim to reduce discrimination among Māori whānau and iwi (fostering capacity for the group to incorporate people experiencing mental illness), and as well, work with Māori with mental illness who have lost their roots to find them and join their whānau and iwi (strengthening identity).

Fonofale
The fonofale model of Pacific mental health, like Māori models of mental health, emphasises community and relationships rather than individuals, and can be used as a philosophy behind anti-discrimination work with Pacific populations.

Human rights sector
The human rights anti-discrimination approach asserts that all citizens have the same civil, political, social, economic and cultural rights. These rights are universal. A core value is people’s right to autonomy or self-determination, which is often denied to people with experience of mental illness. The approach suggests that people with experience of mental illness should be treated as autonomous human beings, just like any other person, even if they make mistakes or decisions no one else agrees with.

Legal remedies are a part of this approach to help ensure people are not prevented from exercising their rights. Educational strategies make sure people know about their rights. Lobbying to extend voting rights to all people with experience of mental illness or promoting the right for people with experience of mental illness to live where they choose, legislating against employment discrimination, or fighting to end forced treatment, are all strategies within this approach.

The human rights approach is potentially powerful, though it could be seen as narrow in its scope. It focuses on formalising (through prohibitions and legal redress) a mainly informal process (everyday discrimination). In this way, it largely ignores the broader social context in which discrimination occurs and does not deal with the subjective or emotional element of discrimination, such as ‘felt stigma’, leading to the feeling of social exclusion (for example, avoiding public places because of a fear of being discriminated against). Human rights education, seeking to inform people about their social, economic and cultural rights, as well as legal rights, is potentially broader in scope.

Disability sector
Disability inclusion
The social model of disability asserts it is discrimination that disables people, not any impairment carried by the individual. Disabled people may be different because of their impairment but their right to be included is equal to non-disabled people. Therefore society has a responsibility to remove barriers to participation experienced by people with disabilities. The New Zealand Disability Strategy (2001) takes this approach which, like the human rights approach, has a clear focus on changing the behaviour of systems and people who discriminate.

Mental health has often been given a less prominent role than physical health in disability approaches, since the disability movement was, on the whole, developed by people with physical and sensory impairments. Also, many people who experience mental illness do not see themselves as disabled. The term disability has been perceived by some to imply permanent impairment, although in fact it covers fluctuating and non-permanent conditions. Moreover, most disabled people expect to improve their ability to live well in the presence or absence of symptoms or impairment.

This analysis of different approaches to mental health anti-discrimination will have been worthwhile if it encourages people engaged in this work to think about and debate their assumptions and philosophies, their strategies and their relationships with agencies doing anti-discrimination work in different sectors.

It has also provided conceptual tools to help understand the work of the different agencies presented in this stocktake.
STRUCTURE OF THE REPORT

*Taking Stock* is divided into several sections. We examine the Like Minds project first, because of its unique and predominant role in the sector. The next, and longest chapter of our report, discusses the roles and functions of central government in mental health anti-discrimination activities. Subsequent chapters deal with national professional organisations and NGOs; regional and local providers, such as District Health Boards, local NGOs, service user groups and public health units; and finally, the research sector, arts and culture, and private sector interests. Finally, we discuss our findings and present some conclusions.
INTRODUCTION

Like Minds, Like Mine: Project to Counter Stigma and Discrimination Associated with Mental Illness

INTRODUCTION

Like Minds, Like Mine: Project to Counter Stigma and Discrimination Associated with Mental Illness/Whakaitia te Whakawhiu i te Tangata is New Zealand’s best resourced, nationally networked mental health anti-discrimination project (and is referred to as the Like Minds project throughout this report). It had its origins in 1996 in recommendations from the Mason Inquiry, which argued that mental illness stigma and discrimination are barriers to developing good mental health services and discourage people from seeking help from services at an early stage; and that communities that lack understanding and are hostile will impede recovery from mental illness (Mason 1996).

Originally scheduled to finish in 2001 after five years of special funding through a 12.6 million dollar allocation of ‘Mason money’, the Like Minds project was twice extended through public health baseline funding and is currently guaranteed funding until 2005.

The Like Minds project is located in the Ministry of Health’s Public Health Directorate and is led by the National Project Manager, who is accountable to the Deputy Director General, Public Health and the Deputy Director General, Mental Health. The National Project Manager heads a two-tier structure and manages the national programme, with the contracting out of regional programmes being done through regional portfolio managers. The national and regional programmes, with different target populations and different kinds of activity, are intended to complement each other.

The project is coordinated through regular meetings of the National Project Manager and the regional portfolio managers, as part of the Ministry of Health’s Mental Health Promotion work-stream meetings. The regional portfolio managers do not have any formal role in overseeing the national project, but they provide input into the strategic direction of the whole project through the work-stream meetings.

The Like Minds project’s National Advisory Group is a representative group of service users/tangata whaiora from around the country and ensures consumer perspectives are incorporated into the project. The National Advisory Group also provides a contact point for consumers and providers in the regions.

At a national level, the Like Minds project receives advice and support from the Mental Health Commission, and communicates regularly with other relevant agencies, such as the Human Rights Commission.

The Like Minds project has published three national plans detailing the project’s philosophy, vision, aims, objectives, strategies and key activities (Ministry of Health 2001; 2003b). Its vision statement, essentially unchanged since 1999, is ‘a nation that values and includes all people with experience of mental illness’ (Ministry of Health 2003b: 6). The National Plan 2001–2003 restated the original central aim of the project as being ‘to reduce the stigma associated with mental illness and reduce the discrimination experienced by people with mental illness’ (Ministry of Health 2001: 2).

The project’s goals and strategies have changed over its course to reflect increasing theoretical and practical understanding of anti-discrimination and destigmatisation activities, new target population groups and changing relationships with key allies. The latest strategic directions are discussed after the project’s national and regional level programmes.
NATIONAL PROGRAMME

The national programme aims to ‘change public attitudes and behaviour through mass media, public relations and health promotion’ (Ministry of Health 2002b) and to engage in various projects best located nationally, such as the Government Policy project. The most notable component of the national programme, and the most visible part of the Like Minds project, has been its mass media campaign, which is accompanied by a strong public relations programme.

Mass media advertising campaign

Benchmark research carried out before the Like Minds project’s mass media advertising campaign documented the negative attitudes towards mental illness noted by the Mason Inquiry (Mason 1996). It found that the public was not interested in mental illness, was ill-informed about mental illness and found mental illness scary (BRC Marketing and Social Research 2002). The advertising agency Foote, Cone and Belding (FCB) was engaged to develop a mass media campaign to reduce the level of stigma and discrimination associated with mental illness.

Working with a reference group from the Like Minds project, target groups for the campaign were decided. They were: general public, Māori and Pacific peoples and youth. It was decided to focus on the group aged 15–44. The communications also needed to work for people with experience of mental illness.

Exploratory work in 1997, carried out by BRC, Mind and Mood workshops (organised by FCB in 1999) and pre-testing of initial concepts and a benchmarking survey (by Phoenix research) before the 2000 advertising campaign was used to identify the following challenges (van den Hurk 2002):

- People had a low level of understanding of, and interest in, mental illness
- The 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
  - regarded ‘serious mental illness’ as ‘not my problem’
- European/Pakeha, 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.

Although the campaign’s aim was to change discriminatory behaviour, it was understood that this 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.

The basis of the initial strategy and concept brief for the first phase of advertising was to give mental illness personal relevance. It needed to communicate that people with mental illness experience have a lot in common with everyone else, overcome people’s lack of interest and counter negative stereotypes. It needed to be positive and ethnically inclusive to avoid ‘buy-out’ from any of the target population groups of general public as a whole, as well as Māori and Pacific peoples.

The advertisements used a range of New Zealand and international, famous and ordinary people who experienced mental illness, raising the question ‘Are you prepared to judge?’ One of the advertisements featured only New Zealanders and the other a combination of New Zealanders and overseas people.

The research literature has established that negative attitudes can be reduced by promoting direct contact between people with experience of mental illness and people who have no such experience. This can be particularly effective when the person with experience of mental illness is perceived as having equal or higher status than the person without. Respected celebrities often have such status, so the campaign was based around using respected celebrities with experience of mental illness.

This first phase of the advertising campaign ran throughout 2000 and 2001. Also in 2001, a one-hour documentary, Sticks and Stones, went into more detail about the lives of some of the well-known New Zealanders featured in the advertisements. It aired on prime time television and was viewed by 300,000 people.

The second phase of the campaign was launched in 2002. It built on the first phase by going into more depth (four one-minute documentary-style advertisements) about the lives of four New
Zealanders featured in the first campaign: All Black John Kirwan, musicians Mike Chunn and Mahinarangi Tocker, and fashion designer Denise L'Estrange-Corbett. Each advertisement included one of their friends, also well known, talking from the perspective of a supportive companion. The tag-line stated, ‘One in five people are affected to some degree by mental illness at any time, and how much they suffer depends on you’. It also asked, ‘Are you prepared to judge?’

Both phases of this ‘famous people’ campaign were remarkably successful, but after considerable thought and consultation it was decided that the next phase would focus on ‘ordinary people’ who had experience of serious mental illness. Three 45-second television advertisements focused on non-Māori, Māori and Pacific people’s experiences of the mental illnesses the general public perceived as serious.

This phase allowed the public to be introduced to a person with experience of a mental illness as a whole person, rather than solely as someone who was unwell. We learn about the person through their family and friends, people with whom the viewer will feel they can relate and trust.

The advertisements tackled the belief that those affected by mental illness ‘live in another world’ and endeavoured to remove the fear and misconceptions around mental illnesses. It portrayed people affected by mental illness living in the same world as everyone else, showing how they contribute in their lives, relationships and communities. The person whose life was being shared asked the viewer to ‘Know me before you judge me’ and the tag line told people that, ‘People can live great lives, but with understanding they can do even more’.

To ensure the people who agreed to be part of the campaign were in control of their involvement, protocols were adopted that allowed the person to withdraw from the campaign at any time, even after the advertising went to air. If a member of the public wanted to talk to someone as a result of the advertising, a freephone number staffed by trained telephone counsellors was made available.

Public relations

Accompanying the advertising campaign was a successful public relations programme driven by Huia Communications. Huia provided high quality resources for the people involved in the Like Minds project, including a website, a quarterly newsletter, educational and promotional material, a media booklet, fact sheets and posters. Huia also coordinated internal project communications with email broadsheets, provider hui and Māori and Pacific hui. It had a liaison role with the media, assisted in coordinating media responses and provided training seminars for trainee journalists.

Evaluations of the mass media advertising campaign

Learning from evaluation has played a key role in the Like Minds project, and substantial resources have been devoted to evaluating the advertising campaign (and, although to a lesser extent, the regional activities). A 1997 BRC Marketing and Social Research study of public opinion was exploratory research that fed into a benchmark survey developed in 1999 prior to any advertising going to air. Over the period of the campaign Phoenix Research carried out or coordinated much of the evaluation work in the form of national surveys.

Follow-up evaluations indicate the media campaign has changed people’s views about mental illness and has encouraged them to talk about mental illness. The advertising campaign has been an outstandingly successful component of the Like Minds project, its success reflected in the professional awards it has received, as well as in the outcome evaluations. The 2002 advertisements won the Effectiveness in Advertising (EFFIE) Award, and the project won the New Zealand Marketing Magazine Award and New Zealand Marketing Magazine Supreme Marketing Award. The campaign has also won a Media Peace Prize.

The national surveys showed that recall of the advertisements was high among the general public, and people responded positively to the advertisements and thought about their messages. They were more successful than other social change advertisements and had a strong impact on Māori and Pacific audiences (Ministry of Health 2001).

Results from the survey conducted after the end of the second phase of the ‘famous people’ advertisements, were particularly pleasing (Wyllie 2002). It showed the highest recall rates, with 79 percent of people
surveyed recalling an advertisement unprompted, compared with 53 percent after the first campaign; and 89 percent recalling an advertisement prompted, compared with 67 percent initially.

The message recalled most frequently from the advertisements was that ‘it can happen to anyone’ (mentioned by 32 percent; compared with 39 percent after the first phase of the campaign). A bigger proportion of people surveyed recalled the message ‘people should be more accepting’ (27 percent compared with 17 percent). The advertisements were successful in prompting discussion, with 73 percent of people surveyed having discussed the advertisements at least once and 30 percent having discussed them at least ‘a few times’.

After the campaign 87 percent of people agreed that ‘people who’ve had a mental illness can still lead a normal life’ (compared with 72 percent in the benchmark survey). Thirty-eight percent disagreed with the statement, ‘people who have a mental illness are more likely than other people to be dangerous’ (compared with 27 percent in the benchmark survey). Eighty percent of people agreed with the statement, ‘I feel I am becoming more accepting of people with mental illness’ (compared with 69 percent in the benchmark survey). Recall of the ‘one in five’ statistic, referring to the number of New Zealanders with mental illness, improved as the campaign progressed.

Indices of social acceptability, such as a willingness to accept someone with a mental illness as a workmate or neighbour, moved strongly upwards as a result of the campaign, and associations of mental illness with shame or rejection declined. Interestingly, there was no change in the proportion of people surveyed who said, ‘I can see ways in which people with mental illness are discriminated against’, perhaps because the advertisements did not focus on specific experiences of discrimination.

One area of concern was that although attitudes towards mental illness generally improved, attitudes towards people with schizophrenia did not. The likely reason is that schizophrenia was not targeted in the advertisements, part of a deliberate decision in the first phases to avoid a focus on diagnostic labelling.

Phoenix Research developed a model of social change for reducing stigma and discrimination (Figure 2), in which attitudinal and behavioural changes in the public are nested in a process that also involves changing the attitudes and behaviours of media and opinion leaders, mass media advertising, empowering mental health consumers, changing attitudes and behaviour among people who provide services to consumers, and changing and better using public policy (Ministry of Health 2001). Working on all these factors – some of which are targeted by the regional programme – should lead to a changed climate of public opinion and then to less discrimination. The model denotes weak and strong paths of influence, conceptualising, for example, the potential influence of consumers on changing attitudes and behaviours in services and institutions they interact with as strong, but their potential influence on general public opinion as weak. This model helps to identify where the best anti-discrimination outcomes can be achieved.
Government policy project

The Like Minds project developed a work programme focusing on discriminatory policy in government agencies called the Government Policy project. This project was contracted to the Wellington branch of the Mental Health Foundation, a national non-governmental organisation (NGO) with a primary focus on promotion and prevention.

In 2000 the Mental Health Foundation produced *Countering Stigma and Discrimination: Organisational policy guidelines for the public sector* (Stephens and Caird 2000) and *Countering Stigma and Discrimination: Service quality guidelines for the public sector* (Caird and Stephens 2000). The documents were complementary. The organisational guidelines set out policies to help public sector agencies meet their responsibilities to counter mental illness stigma and discrimination, and the service guidelines provided more practical advice. The guidelines were trialled with the New Zealand Police in 2000. In 2002, additional work was carried out with the Police and the Ministry of Social Development.

The Mental Health Foundation also carried out background work identifying discriminatory policies in employment, housing and insurance and investigated policy issues relating to parents with experience of mental illness.

Evaluations of the Government Policy project were encouraging, but suggested that a model for appropriate interventions at both national and regional levels needed to be developed and increased coordination was needed between the key agencies that conduct anti-discrimination activities.

The Mental Health Foundation was also contracted to carry out a national survey of people with experience of mental illness and their experiences of discrimination. The purpose of the survey was to gain an understanding of discrimination from a first-hand perspective and its impact on people’s lives. In April and May 2003 a survey was undertaken asking people with experience of mental illness throughout New Zealand about their experiences of discrimination.

![Figure 2. Phoenix model of change for reducing discrimination and stigma against people with experience of mental illness](image-url)
related to mental illness. A total of 785 replies were received. The survey captured a diverse population including Pakeha, Māori and Pacific peoples and covered employment, education, housing, government agencies, financial organisations, family and friends, and community harassment.

The survey report (to be published in late 2004) showed that people report discrimination in all aspects of their lives. A picture emerges of the public believing and acting on common stereotypes of people with experience of mental illness and treating people differently when they disclose their experience of mental illness. Experiences of discrimination leave a lasting impression, and fear of discrimination seems to be as crippling as discrimination itself.

The report concludes that discrimination is something that we all need to address and take responsibility for at an individual, community and systemic level. Its findings and data will be used to develop new research projects and to facilitate discussion with key agencies (for example, the Ministry of Social Development, Child, Youth and Family, the Mental Health Directorate, the Human Rights Commission and the Office for Disability Issues).

Media projects

The role of the media as opinion leaders with significant influence was seen as important. The Like Minds project has a partnership with the Carter Center in Atlanta, USA around funding two New Zealand mental health journalism fellowships. The project has also contributed to a programme developing a service user voice in the media.

REGIONAL PROGRAMME

When the Like Minds project was established, New Zealand’s health delivery was organised around four regional health funders. The regional Like Minds programme was set up to reflect this structure, with four independent regional purchasers of services. Following the restructuring of the health sector, creating 21 District Health Boards (DHBs) to replace the regional health funders, purchasing for Like Minds is now located within the Ministry of Health at the national level, with four regional portfolio managers (Northern, Midland, Central and Southern) overseeing contracted providers in their regions.

Local providers are given a degree of autonomy to develop projects for their local populations, although the Like Minds national plan guides them. In many areas providers negotiate contracts with the Ministry of Health’s regional portfolio manager.

Twenty-seven regional providers cover New Zealand. These providers include mental health organisations, Māori and Pacific organisations, public health units within DHBs, as well as a service user organisation. As we explained in the introduction to this report, organisations from different sectors develop different understandings of and approaches to anti-discrimination and this impacts on the way they carry out their business. This is true for the Like Minds regional providers as well as for the central government agencies we describe in the next chapter. Public health has its mental health promotion approach; Māori and Pacific providers try to develop culturally appropriate models, usually within a public health context; mental health initiatives via regional providers tend to work with recovery approaches; and service user activity tends to be recovery oriented as well.

The main difference between the national and regional activities is that the national campaign focuses on changing the general public’s attitudes, while regional Like Minds providers focus on addressing discriminatory attitudes and behaviours within key organisations and groups in their communities that work with or have contact with people with experience of mental illness.

The organisations and groups targeted in the regional programme include:

- government agencies operating locally such as Housing New Zealand Corporation, Department of Work and Income, New Zealand Police
- mental health services
- students (particularly nursing, medical, social work, journalism and psychology students)
- organisations working in the disability sector
- employers
- the finance sector (banks, insurance, etc.)
- NGOs and community organisations such as Citizens Advice Bureaux, budget advisors and Rotary.

In what follows we take a look at the work of some of the regional providers, organised by sector, in order to gain an idea of the scope of Like Minds regional work.

Regional public health units, as public health providers, hold several Like Minds contracts and carry
out projects such as supporting Mental Health Awareness Week, giving out Respect Awards to mental health providers, and contracting workshops such as the consumer-run Hearing Voices and Discrimination Awareness workshops. Most public health providers develop links with mental health service users, engage in advocacy work and produce newsletters. However, there has been criticism that some public health providers have tended to overlook service users and ignored important differences between effective mental health anti-discrimination activities and generic public health activities.

Some public health providers, such as the Regional Public Health Unit of the Hutt Valley DHB, have been particularly innovative. This unit supported the development of Opening Doors to Understanding (Gordon, 2002), a do-it-yourself manual for running education seminars on mental illness from a consumer perspective, in conjunction with its speakers’ bureau, which provides talks by service users about mental illness. It has a reference group with a governance role that includes people with experience of mental illness and representation from the mental health services of the two Wellington DHBs.

The Mental Health Foundation is a major regional Like Minds provider, delivering activities in the Northern and Southern regions from Auckland and Christchurch offices, as well as the Government Policy and Advocacy project from its Wellington office. Its activities have included:

- supporting district advisory groups involved in anti-discrimination work throughout the South Island
- establishing Vibe, an Auckland support network for people aged 17–29 who have experience of mental illness and which aims to reduce internalised stigma and discrimination
- organising Speakers’ Bureaux
- producing a handbook on working with the media
- undertaking education, training, policy and workforce development.

The Foundation, with its focus on prevention and promotion, could be said to work from a public health model rather than a mental health service model.

New Progress Enterprises in Hamilton is a mental health trust, which became a Like Minds provider and employs consumers. Its Like Minds work includes:

- a newsletter sent to about 285 groups and organisations
- workshops and presentations to government agencies and others
- school talks
- Mental Health Awareness Week events
- web site information
- networking with consumers and other providers.

One of the goals of the Like Minds project has been to increase service user involvement in all areas of the project. At the regional level this has occurred mostly through the employment or voluntary involvement of consumers in projects overseen by non-service user providers. However, the Serious Fun ‘N’ Mind Trust in the Bay of Plenty was established at the beginning of the project as a partnership between consumers, public health and the wider mental health community to do Like Minds work. It was one of the first consumer-led Like Minds providers and it consciously uses community development concepts in its work. The Trust concentrates on attitude change in mental health services, government agencies, employers and other groups that have an impact on the day-to-day lives of consumers. It uses education (such as Hearing Voices workshops) and arts and theatre as its main vehicles for attitude change and has initiated projects such as the Respect Awards in the Bay of Plenty area, Breaking the Stigma Wall art exhibition and music CDs performed by service users singing about mental health issues. The Trust, making an effort to work closely with mental health services, has a representative on the trust board of each of the two DHB mental health services in the region.

Māori participation and initiatives are also central to the project given the high rates of mental illness in this community and the double stigma experienced by Māori – being Māori and having experience of mental illness. Seven Māori providers at the regional level deliver to mainly Māori audiences, including:

- Hapai Te Hauora, which delivers to Māori in Auckland by providing regular hui and panui (newsletters), developing training and educational packages for marae-based communities and doing policy work
- Raukura Hauora O Tainui, which works in the Waikato region to develop networks with iwi
• Te Awa O te Ora, which works in Canterbury to promote understanding, develop networks and deliver training and education.

Pacific peoples also face high rates of mental illness and the burden of a double stigma. The three main providers for this community are:

• Pacificare Trust in Auckland, which trains consumers and workers, develops resources, conducts workshops for families and consumers, and undertakes policy work
• Pacific Island Community Health Services (PACH) in the Wellington region, which delivers training to consumers to facilitate workshops and delivers programmes to priority audiences such as family, churches and mental health workers
• Crown Public Health, a division of Canterbury DHB, which supports, informs and educates Pacific consumers, families and communities about mental illness.

Evaluating the regional projects has been more complex than the survey evaluations of the national mass media campaign, because there are a considerable number of providers engaging in a wide variety of activities with different goals and target groups. Therefore, it has not been possible to clearly demonstrate progress in the same way as for the mass media campaign, even though some particular activities have been accompanied by evaluation. For example, the Wellington Consumers Union evaluated the impact of mental health awareness workshops, showing that despite the fact that people who came to workshops tended to be more aware than the general public of stigma and discrimination, their participation resulted in strengthened positive attitudes and shifts in more negative attitudes; and the workshops were satisfying to the participants (Goldsack 2001).

The overall evaluations of regional Like Minds projects are largely qualitative and interpretive, providing detailed accounts of contracted activities and working relationships but little information about the effect of the activities. (These sources discuss the regional evaluations commissioned by Like Minds: Gilbert 2003; Hansen and Ackroyd 2002; Milburn 2002; Ministry of Health 2001; Ministry of Health 2002b; Ministry of Health 2003b; also, opinions on regional activities are included in the CRESA report (2002) commissioned by the Mental Health Commission).

The following issues arose from the regional evaluations:

• Providers vary in quality. Some providers deliver excellent and focused activities, but others show less appreciation of how to best meet the goals and requirements of an anti-discrimination project. In particular, some providers, inexperienced at the beginning of a project, began somewhat haphazardly, working from their strengths, but setting up structures and staffing without clear rationales and strategies and developing activities as they saw fit. While this resulted in some excellent and innovative initiatives, some structures are by now perhaps a little fixed in their ways and resistant to change.
• Providers who combine Like Minds delivery with other mental health service delivery often have less effective Like Minds outcomes, because the boundaries between the two areas get blurred.
• Consistent and coherent overall strategies and approaches need to be developed nationally, since the diverse perspectives of local project teams can be a barrier to effective activities. More emphasis on community development and human rights approaches is also needed.
• Greater service user participation is needed. Although service user involvement is high with some providers, others have needed educating about the importance of involving service users and encouragement to develop good practice in relation to the roles of consumers and their status and remuneration. While some providers use consumers as voluntary workers, there have also been instances of providers paying individuals far in excess of market rates. There is some evidence of token, and even abusive, use of consumers, causing them to become distressed. On the other hand, there are providers making genuine efforts to involve consumers in meaningful ways, for example, as advisors, trainers, facilitators and trustees.
• Providers could benefit from more training, workforce development and capacity building, because the skill mix needed for anti-discrimination programmes is hard to get. Anti-discrimination work needs a mix of skills across the training, health promotion, mental health and anti-discrimination sectors. Currently there are no recognised qualifications bearing directly on this field of work.
• Strategic relationships with other agencies are important.
• Effective targeting is important, but is sometimes insufficiently strategised.
• Some activities do not appear to have a high impact for the resources used. Activities such as drama productions may not deliver good value for money as once the actors finish there is no ongoing resource. More work needs to be done to ensure the effectiveness of public speakers and more needs to be learned about the best ways to provide effective workshops.
• More work needs to be done to ensure support for public speakers who disclose their experience of mental illness.
• More effective strategies to work with mental health service providers need to be devised. Service user participation in Like Minds is redefining the relationship with professionals in mental health services, and a partnership approach to devising appropriate strategies is recommended.
• Regional government agency work needs to be better coordinated.
• A strategy needs to be devised for working with primary health care providers.
• Hostile media can undo much good work.
• Many Māori providers have performed well, but others have had problems with roles, responsibilities and accountabilities, and there seem to be some gaps in delivery.
• More evidence is needed that regional programmes are making a difference. A lot of data have been collected that provide a valuable resource for further analysis and interpretation, but more research and evaluation needs to be targeted at areas raised as problematic. Providers need more evidence about what works and what does not.

STRATEGIC DIRECTION

The Like Minds project's national plans demonstrate how the project has developed.

The first national plan, appearing three years after the project started in 1996, was an internal document setting the foundations for progress through infrastructure development, network building, and the establishment of relationships with key agencies such as the Mental Health Commission (Health Funding Authority 1999).

The second national plan, which was published, identified the need for Māori and Pacific perspectives to be developed and acknowledged the need for family involvement and increasing consistency between the national and regional programmes (Ministry of Health 2001).

The third national plan focuses more on incorporating theoretical approaches to anti-discrimination into planning of activities (Ministry of Health 2003b). While a public health approach has dominated the project’s activities, this plan signals a shift to more direct attacks on discrimination using the human rights and social disability approaches. This theoretical positioning strengthens the relationship between the Like Minds project and the Human Rights Commission, while also clearly identifying the relevance of human rights law, both national and international (see section 2, Central government). The social disability or disability inclusion approach, which places mental illness within a wider disability framework, identifies a new relationship between the Like Minds project and Office for Disability Issues.

The third plan articulates seven objectives to strengthen the Like Minds project as a result of the evaluations:

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. (Ministry of Health 2003b)

Objective 1 involves a strong focus on developing a consumer workforce.

Objective 2 focuses on relationships with the Mental Health Commission, Human Rights Commission and Office of Disability Issues, as well as a wide range of mental health service providers and community groups.

Objective 3 focuses on discriminatory practices generally, but emphasises working with mental health services and contributing to the implementation of Standard 18 of the National Mental Health Standards (see section 2, Central government).

Objective 6 enables, for the first time, a focus on Asian peoples and recommends developing relationships and activities with Asian communities.

Objective 7 includes an emphasis on developing theoretical frameworks and applied knowledge in the Like Minds project, as well as encouraging further monitoring and evaluation.

Overall, the Like Minds project has been a strong force in anti-discrimination activities. It has been well run at a national level and its mass media advertising campaigns have been effective. Located in the public health sector, it has drawn on Ottawa Charter values and mental health promotion approaches, but it has also been strongly influenced by recovery approaches arising from its service user constituency via input from its National Advisory Group, and from its close connection with the Mental Health Commission. Human rights and disability inclusion approaches have also been fostered as the project began to focus more on government policy, and the letting of contracts to Māori and Pacific providers have encouraged the development of culturally appropriate anti-discrimination initiatives.

Like Minds regional providers have engaged in a wide range of activities with mixed, but largely undocumented, outcomes, although as organisations their work has been evaluated. Performance, as far as it can be judged, has ranged from inspirational to poor. Continuing efforts from the national level will sort out any ongoing regional performance problems, particularly through an emphasis on workforce development and collaboration.

More understanding of the implicit approaches to anti-discrimination being used at regional level will help with future planning. It has been recognised that different types of providers tend to deliver different types of programme, but the analysis in this stocktake of the ways in which sector location – public health unit, mental health NGO, service user organisation, Māori and Pacific health provider and so on – tend to determine the approaches chosen (goals, strategies, analysis of stigma and discrimination) should be helpful in refining approaches, looking at gaps and developing key relationships.

Moreover, in thinking about the long-term future of Like Minds, its sector location should be considered. Its location in public health has been one key to its success, but as the project moves forward into more directly tackling discrimination, it could benefit from a closer alignment with service user organisations and disability, mental health and human rights sectors.

Overall, in moving from raising awareness to directly engaging with mental health stigma and discrimination, Like Minds has made a huge difference to social inclusiveness in New Zealand, and is poised to make an even greater difference.
Government’s role in mental health anti-discrimination activities is far-reaching. The ways in which government furthers anti-discrimination includes devising and implementing laws, strategies and policies; implementing anti-discrimination measures in its workplaces; promoting anti-discrimination in mental health services; delivering anti-discrimination programmes to the public via Like Minds and public education settings; and offering remedies for discrimination through sources as varied as the Health and Disability Commissioner and the Office of Film and Literature Classification.

In this chapter we examine the role of central government in anti-discrimination activities. By central government we mean government agencies with a national role or function, such as ministries, departments and commissions. As we noted in the introduction, it is helpful to think of mental health anti-discrimination activities as situated within four sectors (see also Figure 1):

- mental health
- public health
- human rights
- disability.

We have organised our discussion of central government around this way of defining sectors.

Each sector is guided by legislation and policies, setting overall directions that impact, directly or indirectly, on mental health anti-discrimination activities. The mental health and disability sectors have associated government strategies: the New Zealand Disability Strategy (Minister for Disability Issues 2001) and the Mental Health Strategy (Ministry of Health 1994 and 1997). Building on Strengths, the mental health promotion strategy document, guides the public health sector (Ministry of Health 2002a); while the human rights framework for anti-discrimination is in the Human Rights Act 1993 and its amendments and the New Zealand Bill of Rights Act 1990.

Government agencies have a variety of roles and responsibilities relating to mental health anti-discrimination that arise from these overarching strategies, frameworks and legislation. In this section, which is organised around the four sectors, the key agencies and their work are examined, including the Ministry of Health, Mental Health Commission, Ministry of Justice, Human Rights Commission, Health and Disability Commission and Office for Disability Issues.

Other government agencies that do not fit within these four sectors also carry out some work of particular relevance to anti-discrimination and they are discussed separately. They include the Ministry of Youth Development, the Department of Work and Income, the State Services Commission, the Ministry of Education, Creative New Zealand and the Office of Film and Literature Classification. Our coverage outside the four sectors is not comprehensive, as all parts of government have some requirement to be involved in mental health anti-discrimination activities. All government agencies must ensure their policies and operations are consistent with the human rights, disability and mental health frameworks. Also, they must promote this consistency within the sectors they represent and act as good employers. Thus, even agencies that might be thought irrelevant to the task of ending mental health discrimination, such as the Ministry of Agriculture and Fisheries, have a role to play in the overall anti-discrimination work of government.
MENTAL HEALTH SECTOR

The key central government agencies in the mental health sector are the Ministry of Health and Mental Health Commission.

Ministry of Health and its Mental Health Directorate

The Ministry of Health, through its Mental Health Directorate, has the leading role in mental health policy development and purchasing mental health services. The Directorate prepares national strategic plans and, with Standards New Zealand, develops performance standards for the mental health sector.

National mental health strategies and plans

New Zealand’s mental health strategy is described in two documents: Looking Forward (Ministry of Health 1994) and Moving Forward (Ministry of Health 1997). Looking Forward outlines the general goals and strategic direction for the development of mental health services over a 10-year period. Moving Forward is a plan that expands Looking Forward by introducing more detail, targets and standards.

The overall mental health strategy is embedded in New Zealand’s Health Strategy (Ministry of Health, 2000). The strategy has 13 population objectives, one of which is to ‘improve the health status of people with severe mental illness’, while also improving the responsiveness of mental health services. The mental health strategy is further developed for particular communities with more specific strategies, including the Māori mental health strategy, Kia Mau te Hauora Hinengaro (which calls for greater responsiveness to Māori and Māori participation in the planning and delivery of services) and the Pacific Health and Disability Action Plan (which emphasises improving mental health status, services, workforce capacity, consumer participation and research for Pacific communities) (Minister of Health 2002). The mental health framework for anti-discrimination work has its roots in these key health documents.

Within Moving Forward a commitment to anti-discrimination is indicated at the outset:

the stigma which is attached to mental illness in the community (and which is reinforced by well-publicised tragedies and incidents) must be addressed. Elimination of this stigma – and the discrimination against people with mental illness that results from it – is necessary for encouraging potential consumers to seek early intervention and treatment for their disorders. It is also necessary for making mental health services more attractive as a career (Ministry of Health 1997: 10).

Within Moving Forward, anti-discrimination is detailed within strategic directions four (balancing personal rights with protection of the public) and seven (strengthening promotion and prevention).

Strategic direction four outlines the need to maintain a balance between:

- mental health and criminal justice legislation which imposes compulsory treatment and restriction of normal liberties on mentally disordered individuals with
- the usual rights and freedoms of the individual and
- the public interest, in particular the safety of the public. (Ministry of Health 1997: 27)

The first point, relating to rights, is of particular interest in terms of anti-discrimination work.

Strategic direction seven embodies the main focus of anti-discrimination efforts:

- To increase public knowledge and awareness of mental health issues in order to:
  - create a more supportive environment for people living with a mental illness
  - help remove the barrier of discrimination and stigma that stops people seeking early assistance and support (Ministry of Health 1997: 34).

The first point of this strategy articulates a recovery approach, and the second a medical model approach to anti-discrimination.

A second national plan for mental health is currently being developed and is likely to be available in 2005.

Mental health anti-discrimination standard (Standard 18)

The National Mental Health Sector Standard describes the minimum standards for government-funded mental health providers (Standards New Zealand 2001b). Standard 18 (reducing discrimination and promoting community acceptance) is the standard dealing with anti-discrimination in mental health services, so it, and its criteria, are worth reproducing.
The mental health services promotes mental health and community acceptance of people affected by mental illness and mental health problems.

Promotion of Mental Health

18.1 The mental health service works with staff to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service.

18.2 The mental health service works collaboratively with consumers, family, whānau, health promotion units, personal health services, local authorities, key agencies and other organisations (for example, the Department of Work and Income, Housing New Zealand, Police, Justice) to conduct and manage activities which promote mental health and minimise the onset of mental illness or mental health problems.

18.3 The mental health service provides information to other services and actively works with consumer groups and other community groups to provide information about mental illness and mental health problems as well as factors that prevent mental illness and mental health problems.

This may include and is not limited to ensuring:
(a) Community development models are used, or joint programmes developed with other agencies;
(b) Consumers are involved in the education of the community and other services;
(c) Contracts with media organisations are established and maintained.

Community Acceptance

18.4 The mental health service actively works with consumer groups and a range of community agencies to promote acceptance of, and reduce discrimination against, people with mental illness and mental health problems.

This may include and is not limited to ensuring:
(a) Consumer groups, individuals and organisations have the opportunity to be involved in aspects of these activities, such as promoting the positive image of people with mental illness (Mental Health Awareness Week), school education programmes and public information seminars;
(b) Local bodies are involved.

18.5 The mental health services ensure that staff have knowledge of the barriers to recovery posed by discrimination, including discrimination against people with mental illness by the wider community and by the mental health workforce.

This may include and is not limited to ensuring the mental health service:
(a) Promotes the use of non-labelling in relation to people with a mental illness or mental health problems;
(b) Encourages the community to view those with mental disorders or mental health problems holistically, rather than in diagnostic terms eg, labelling people with diagnostic terms rather than using their name is actively discouraged, as it is discriminatory.

The intention of Standard 18 is to ensure:
1. The service eliminates discriminatory practices in its own environment.
2. The service works with all other stakeholders (consumer groups, family groups, public health staff, etc) to participate in activities that promote mental health and work towards reducing discrimination.
3. Staff understand barriers to recovery by discrimination and work against them. (Platform 2003)

The mental health standards are applicable to all mental health and disability service providers receiving government funding (including services that administer as well as those providing direct services) and they had to be met by mid-2004. Under the Health and Disability Services (Safety) Act 2001 providers have to meet the standards if they provide:

Mental health services are regularly assessed against the standards through a monitoring regime that includes self-audits, reports to funders, and independent audits and reviews. The standards are minimum standards, benchmarks for a quality mental health service where continuous quality improvement is expected.

The mental health standards were designed to work alongside the Code of Health and Disability Services Consumers’ Rights (for further details about the Code,
see Health and Disability Commissioner’s Office, below). The standards also align with the Health and Disability Sector Standards (Standards New Zealand 2001a), which were developed after the mental health standards. Although the standards overlap, especially in relation to consumer rights, Standard 18 uniquely provides for anti-discrimination efforts.

**Mental Health Directorate: Other policy and strategic functions**

The Mental Health Directorate also leads programme implementation, monitors funding and purchasing arrangements, develops policy and advises the Government on mental health priorities in relation to the strategy.

Within the Directorate a policy team oversees the Mental Health Strategy and projects and activities that contribute to its implementation. This team also carries out smaller projects, including a recent review of all legislation in order to identify any provisions that could be discriminatory towards people with experience of mental illness.

Also within the Mental Health Directorate is the Rights and Protection team, which is responsible for:

- **Legislation** – reviewing legislation and legislative proposals from across government for their effect or potential effect on the Mental Health Strategy and mental health consumers.

- **Regulation** – responding to local and regional authority proposals and advising on their effect or potential effect on the Mental Health Strategy and mental health consumers.

- **Policing and criminal justice policy** – responding to proposals from the New Zealand Police, Ministry of Justice and Department of Corrections and advising on their effect or potential effect on the Mental Health Strategy and advising mental health consumers.

- **Individual complaints** – advising complainants how to deal with complaints and referring them to appropriate authorities.

Each of these responsibilities relates to anti-discrimination objectives in a variety of ways. For example, anti-discrimination is an important component of the Mental Health Strategy, so reviewing legislation, responding to regional authority and Police proposals allows current and ensuing legislation, policy and regulation to take account of the strategy’s aims and intentions. Providing advice and appropriate referral to complainants allows protections within legislation and complaints systems to function better.

The Mental Health Directorate jointly oversees the Like Minds project with Public Health.

**Summary**

The Ministry of Health’s role is central in anti-discrimination work. It includes anti-discrimination goals and standards in national mental health policy and it funds Like Minds. In terms of its approach to anti-discrimination, it blends a medical model, emphasising that stigma and discrimination prevent access to mental health services and impede good service delivery, with recovery approaches, with an emphasis on enabling community acceptance and social inclusion for mental health service users. Through its involvement with the Like Minds project, the Ministry also frames some of its activities within public health/mental health promotion models. In terms of human rights perspectives, there are some areas of potential clash with anti-discrimination activities, since the Ministry develops and administers legislation authorising compulsion against service users in certain circumstances.

**Mental Health Commission**

The Mental Health Commission was established in 1996 in response to the inquiry into mental health services (Mason 1996). Guided by the Mental Health Commission Act 1998 (section 6), the Commission has three main functions:

- To monitor and report to the Government on the performance of the Ministry of Health in the implementation of the National Mental Health Strategy

- To strengthen the mental health workforce

- To work with the sector to promote better understanding by the public of mental illness, reduce stigma and eliminate discrimination. (www.mhc.govt.nz).

These functions all contribute to anti-discrimination objectives in some way. The strong emphasis on anti-discrimination work in the legislation is a direct result of the emphasis given it by the Mason Inquiry.
Monitoring and reporting

The Commission reports to the Minister of Health on progress towards the implementation of the National Mental Health Strategy. The Commission’s Blueprint for Mental Health Services in New Zealand (1998a) shows how the strategy should be operationalised. It was adopted as government policy. The Blueprint makes a strong argument for the importance of anti-discrimination efforts, stating that “a discrimination-free environment is necessary if the Government’s Mental Health Strategy is to be implemented” (p.19).

The Blueprint is underpinned by a strong recovery approach. This involves a holistic approach to mental health service delivery that takes into account the whole (non-discriminatory) environment that is needed to contribute to a person’s recovery from mental illness. The recovery approach requires services to empower service users, assure their rights, achieve best outcomes, increase their control over their mental well-being and enable them to fully participate in society.

The Commission produces regular progress reports on mental health, which usually include an assessment of progress with anti-discrimination initiatives, including the Like Minds project. It also has had input into the second mental health plan, and encouraged a service user vision for mental health as a contributor to the plan called Our Lives in 2014: A Recovery Vision from People with Experience of Mental Illness (2004).

Strengthening the workforce

Anti-discrimination measures in the mental health workforce are promoted through various Commission initiatives. In 2002, a recruitment programme sought to increase the workforce participation of Māori and Pacific people, an indirect anti-discrimination approach where cultural relevance is used to create more appropriate service user and staff interaction and understanding. This programme was repeated in 2003 but was targeted to Pacific people. The Commission also developed the Recovery Competencies for New Zealand Mental Health Workers (MHC 2001c) and a teaching resource to help train future providers.

Recovery Competencies describes the competencies need to further anti-discrimination goals. A competent mental health worker understands and actively protects service users’ rights by demonstrating:

- knowledge of human rights principles and issues
- knowledge of service users’ rights within mental health services and elsewhere
- an ability to promote and fulfil service users’ rights (MHC 2001c: 16).

A competent mental health worker understands discrimination and social exclusion, its impact on service users, and how to reduce it by demonstrating:

- knowledge of discrimination and social exclusion issues
- an understanding of discrimination and exclusion by the wider community
- an understanding of discrimination by the health workforce
- an understanding or other kinds of discrimination and how they interact with discrimination on the grounds of mental illness
- familiarity with different approaches to reducing discrimination (MHC 2001c: 18).

Anti-discrimination

The Commission’s functions and statutory requirements in anti-discrimination activities are found in s 6(c) of the Mental Health Commission Act 1998:

(c) To work with all those involved in the care and treatment of people with mental illness and their families and caregivers —

(i) To promote better understanding, by the community, of mental illness; and

(ii) To reduce the stigma associated with mental illness and the prejudice shown to people with mental illness and their families and caregivers; and

(iii) To eliminate discrimination on the ground of mental illness against people with mental illness and their families and caregivers.

Within the Commission, the Journeys towards Equality Team (JET) works on initiatives that concentrate on building strong service users and strong inclusive communities to combat stigma and discrimination. The work is concentrated in the following areas:

- encouraging service user participation in all facets of mental health and the wider community
- working with District Health Boards to encourage service user-oriented, non-discriminatory practices in mental health care, with a special focus on service users’ rights
• providing input into government policy, especially in the areas of housing, employment and welfare benefits
• liaising with other key agencies involved in anti-discrimination work, such as the Like Minds project, Mental Health Foundation, Human Rights Commission, the Health and Disability Commissioner and the Office of Disability Issues
• undertaking educational projects such as publications (including print, video and CD-Rom) and events
• working with media to reduce unfavourable and stereotypical coverage of mental illness
• researching stigma and discrimination, with ongoing projects including one on service user views of mental health services which asks about stigma and discrimination, amongst other topics, and another investigating the experiences of service users who ‘champion the cause’ of mental health anti-discrimination
• exploring human rights issues relating to the use of compulsion towards service users.

In 1998, the Commission produced its first conceptual and strategic document in the area of mental health anti-discrimination, *A Travel Guide for People on the Journeys towards Equality, Respect and Rights for People who Experience Mental Illness* and an associated Map of the Journeys (discussed in the introduction). As we noted, the Travel Guide placed an emphasis on discrimination rather than stigma, because stigma directs attention to the people who are the recipients of prejudice, whereas discrimination focuses on those who engage in prejudiced behaviour.

As well as the Travel Guide, the Commission has produced other publications in the area of anti-discrimination, including:

• an examination of discrimination and strategies to reduce it (Thompson and Thompson 1997)
• *A Gift of Stories* (Leibrich 1999 published by University of Otago Press with assistance from the Commission) captures the experiences of service users and how they coped with mental illness
• *The Discrimination Times* (MHC 2000), a survey of media representations of mental illness which has been repeated in 2004
• *Finding a Path Through Local Planning Processes*, a handbook for people involved in community housing who may encounter discrimination from communities (MHC 2000)
• *Housing Checklists* (MHC 2001) – secure and safe housing is one of the most important components of a person’s recovery from mental illness. The checklist is aimed at the health, housing and income support sectors and asks questions such as ‘How is the level of discrimination in the rental market against people with mental illness being monitored?’
• *Employment Checklists* (MHC 2001) – similar to the housing checklist but aimed at the health, employment, education and income support sectors
• ‘*Kia Mauri Tau!* Narratives of recovery from disabling mental health problems* (Lapsley, Nikora and Black 2002) – 40 narratives of mental ill health, recovery and life after recovery from Māori and non-Māori women and men, which includes a discussion of stigma as the most significant barrier to recovery
• *Service User Participation in Mental Health Services: A Discussion Document* (MHC 2002c) – a review of targets set out in the National Mental Health Strategy under objective 3.2; involvement of consumers is one way to eliminate discrimination within services
• *Service Users Discuss Mental Illness and Recovery* (MHC 2003b) – a video used as a teaching resource to encourage thinking about recovery from mental illness. It includes a section on stigma
• *Physical Health of Service Users….Who Cares?* (MHC 2004), a discussion paper examining the poorer physical health of service users, and arguing that discrimination is a cause.

Most of these resources are available on the Commission’s website (www.mhc.govt.nz).

The Commission has also undertaken several projects on media discrimination, since the media play a crucial role in influencing public opinion. These projects include a survey of mental health media spokespersons, a forum following up on the survey, and a project, in association with Like Minds, to enhance service user voices in the media. It also produced three fact sheets on mental illness and crime to correct misleading media messages and clarify the often mistaken connection between mental illness and crime. These factsheets are aimed at people who speak to the media:

• *Factsheet One: Mental illness and violent crime* (MHC 2002a)
• Factsheet Two: Homicide and mental illness (MHC 2002b)
• Factsheet Three: Mental illness, crime and the justice system (MHC 2003a).

The Commission also issues regular media releases, some of which focus on discrimination.

In addition, the Commission works with external agencies and undertakes policy work and government liaison. It has made submissions on various Bills and has worked on policy in relation to housing, employment, benefits, electroconvulsive therapy and resource consents. It liaises closely with other agencies involved in anti-discrimination, such as Like Minds, the Human Rights Commission, the Health and Disability Commissioner, the Office of Disability Issues and the Mental Health Foundation.

Overall, the Commission’s role in the mental health sector involves providing leadership through monitoring and innovation. As the only agency with a statutory requirement to conduct anti-discrimination work in the mental health sector, the Commission is placed at the centre of this activity.

An evaluation of the Commission’s anti-discrimination work shows it is working within a recovery philosophy, as well as embracing aspects of the human rights and disability inclusion approaches (McCurdy 2002). The recovery approach, as explained earlier, is a mental health approach to anti-discrimination focusing on service user empowerment and recognising wider factors such as housing and employment as important to a person’s recovery from mental illness. The recovery approach reflects strong service user involvement in the Commission, where people with experience of mental illness are represented amongst Commissioners and staff, with at least one staff position specifically providing service user advice. Also, the Commission has a service user reference group and service user representatives on its advisory body.

The Commission is especially well placed to take a lead in encouraging anti-discrimination activities in mental health services, a facet of anti-discrimination work that the Like Minds project has so far found challenging. This is because a monitoring role in relation to mental health services is emphasised in the Commission’s guiding legislation.

PUBLIC HEALTH SECTOR

Public Health Directorate, Ministry of Health

The Public Health Directorate is structurally central to the anti-discrimination sector, because this is where the Like Minds project is based, although the project also receives funding from the Mental Health Directorate. By outlining the philosophical basis and strategic directions of public health in New Zealand, we identify the context in which Like Minds sits.

Public health involves an organised effort to protect, promote and restore the health of whole populations, aiming to reduce disease, premature death and disease-related discomfort. As an integral part of the public health approach, health promotion aims to assist people to increase control over, and improve their health. Mental health promotion aims to improve the mental health status of populations. Overall, public health brings to mental health anti-discrimination initiatives a wide scope, focusing as it does on the health and resourcefulness of whole populations. It can also focus on populations at risk, including people with experience of mental illness.

The Public Health Directorate has adopted the widely-acclaimed international standards embodied in the Ottawa Charter for Health Promotion (World Health Organisation 1986) as its model for health promotion. The Ottawa Charter takes a broad view, suggesting that:

To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO 1986:1)

The Charter proposes that to improve the health of populations and individuals there is a need to do more than just provide health services. If people are able to take responsibility for the health of their families and themselves they need:

• Adequate housing
• A liveable income
• Employment
• Educational opportunities
• A sense of belonging and being valued
• A sense of control over life circumstances (Ministry of Health 2003a: 35).

The principles of the Jakarta Declaration on *Leading Health Promotion into the 21st Century* (1997) are also emphasised by the Public Health Directorate. Its priorities for health promotion include:

• promoting social responsibility for health
• increasing investments for health development
• consolidating and expanding partnerships for health
• increasing community capacity and empowering the individual
• securing an infrastructure for health promotion.

The public health strategy, *Achieving Health for All People: Whakatutuki te Oranga Hauora Mo Nga Tangata Katoa*, provides a framework for action (Ministry of Health 2003). Its five key objectives are to:

• strengthen public health leadership at all levels and across all sectors
• encourage effective public health through public health services and action across the whole of the health sector
• build healthy communities and healthy environments
• make better use of research and evaluation in developing public health policy and practice
• achieve measurable progress on public health outcomes.

Improving the entire population’s mental health status is one component of this overarching public health strategy. *Building on Strengths: A Mental Health Promotion Strategy* (Ministry of Health 2002a) fleshes out this strategy specifically for mental health promotion.

*Building on Strengths* aims to:

• serve as an education tool for the health sector as well as other sectors
• outline the Ministry of Health’s planned priority actions for mental health promotion

• guide health sector providers and other sectors on what they can do to contribute to positive mental health and well-being for New Zealanders.

The intended outcomes for the Mental Health Promotion Strategy are wide in scope (Ministry of Health 2002a: 2):

• For the *individual* – resiliency, life skills and mental well-being
• For the *community* – access to mental health promotion services, safe environments, social networks and social support, cohesive communities
• For the *sector* – mental health promoting policies, partnerships and programmes to reduce structural barriers to positive mental health.

Mental health promotion involves developing and implementing:

• healthy public policy that recognises that the health status of people is influenced by factors outside the health sector, such as housing and employment
• community development, that is, people getting together, communicating, identifying priority needs, planning and taking action to resolve problems and achieve outcomes desired by the community
• primary mental health care by developing general practice capacity
• strengths by building on the abilities of individuals and communities
• a recovery approach, that is, a holistic understanding of living well in the presence or absence of mental illness (here the strategy uses the Mental Health Commission definition of recovery).

*Building on Strengths* acknowledges the importance of the contribution that people with experience of mental illness have to make in prevention and promotion endeavours, and emphasises that people with experience of mental illness are a population group who should receive health promotion interventions. The importance of working against discrimination is also emphasised.
Ma¯ori and Pacific mental health and health promotion models

Building on Strengths also emphasises the key importance of the Treaty of Waitangi to health promotion, and argues that the Ma¯ori and Pacific models of health and mental health must be incorporated into health promotion strategies, including anti-discrimination work, in a manner that is relevant to Ma¯ori and Pacific peoples. The health models it refers to are:

- **Te Pae Mahutonga**, a model of health that brings together factors as they apply to Ma¯ori health:
  - Te oranga – participation in society
  - Toiora – healthy lifestyles
  - Ngā manakura – community leadership
  - Waiora – physical environment
  - Mauriora – cultural identity
  - Te mana whakahaere – autonomy.

- **Te Whare Tapa Wha**, a model of mental health, which uses the four sides of a house to represent different components of health (taha wairua – spiritual health; taha hinengaro – mental health; taha tinana – physical health; taha whānau family health). Health is seen as being a balance of these different components, and the model suggests that if one of these walls fails, the house will fall (Durie 1998).

- the **Fonofale model of health**, which is a model based on a Samoan perspective of health that describes health in terms of the traditional Samoan meeting house: the roof (shelter provided by cultural values), the foundation (nuclear and extended family); and the four supporting structures, or dimensions of health: spiritual (Christianity and traditional spirituality), physical (biological well-being), and psychological (the mind) and social (Mental Health Commission 2001d).

Within Te Puawaitanga: Māori Mental Health National Strategic Framework, one of the strategic objectives is to ensure links with the Like Minds project (Ministry of Health 2002c). Similarly, the Pacific Health and Disability Action Plan sought to improve Pacific mental health status through promotion and prevention activities, which by their nature imply anti-discrimination initiatives (Ministry of Health 2002d).

In a sense, the health promotion approach sits at the front end of anti-discrimination work, attempting to prevent mental illness discrimination by fostering an understanding of its causes and increasing the mental well-being of whole populations and at-risk groups, rather than trying to remedy discrimination once it has manifested itself (a feature of human rights and disability inclusion approaches).

**HUMAN RIGHTS SECTOR**

The human rights emphasis in mental health anti-discrimination activities is largely driven by three agencies: the Ministry of Justice, the Human Rights Commission and the Office of the Health and Disability Commissioner. These agencies have complementary roles: the Ministry of Justice develops and implements policy and law (for example, and of particular interest, the New Zealand Bill of Rights Act 1990 (Bill of Rights Act)); the Human Rights Commission promotes human rights and harmonious relations between diverse groups in New Zealand society and has a disputes resolution function; and the Office of the Health and Disability Commissioner works to promote and protect the rights of health and disability services consumers.

The Office of the Ombudsmen is a further agency of relevance to human rights and anti-discrimination. As an ‘office of last resort’ it can review decisions of the Health and Disability Commissioner and also deal with or refer on complaints of discrimination concerning agencies outside the health sector. It is beyond the capacity of this stocktake to describe the roles and functions of all of the many agencies, as widely varied as the Banking Ombudsman and the Press Council, whose functions include providing remedies for discrimination (including, potentially, mental health discrimination), as opposed to undertaking anti-discrimination work.
Ministry of Justice

The Ministry of Justice contributes to anti-discrimination in the mental health sector through its oversight of key human rights legislation. Most importantly, the Ministry administers the Bill of Rights Act and vets all Bills introduced into Parliament for consistency with that Act, except for those sponsored by the Ministry. The Crown Law Office provides advice to the Attorney-General about Ministry of Justice-sponsored Bills. The Bill of Rights Act and the Ministry’s vetting process provide broad protections against discrimination.

The vetting process means any Bills found to be inconsistent with the Bill of Rights Act must be reported to the House of Representatives, so the inconsistency can be debated within the House. The Act may also be used in the High Court to challenge alleged discrimination.

The long title to the Bill of Rights Act says it is an Act:

a) To affirm, protect, and promote human rights and fundamental freedoms in New Zealand; and

b) To affirm New Zealand’s commitment to the International Covenant on Civil and Political Rights.

The Act was established to protect citizens’ individual rights against abuses by the state. Therefore, the Act applies to actions:

(a) By the legislative, executive, or judicial branches of the government of New Zealand;

(b) By any person or body in the performance of any public function, power, or duty conferred or imposed on that person or body by or pursuant to law. (Section 3 of the New Zealand Bill of Rights Act 1990)

The Ministry of Justice drafted the Human Rights Amendment Act 2001. Among the amendments was the introduction of Part 1A into the Human Rights Act 1993, which requires the public sector to comply with the Human Rights Act. The Bill of Rights standard, as opposed to the Human Rights Act standard, applies to the public sector except in the areas of employment and racial and sexual harassment, where the Human Rights Act standard applies. The application of the Bill of Rights standard means that the government may act in a discriminatory manner if this can be “demonstrably justified in a free and democratic society”. This allows for the balancing of competing interests. This sets a high benchmark, but at the same time allows for the balancing of competing interests by the government.

Part 1A of the Human Rights Act relates to discrimination by government agencies and associated bodies and allows complaints to be laid against such agencies under the Human Rights Act framework. The amendment is far-reaching, as is evident in guidelines prepared by the Ministry of Justice that aim to strengthen the consideration of human rights at an early stage of policy development.

Part 1A of the Human Rights Act applies to any act done by the legislative, executive, or judicial arms of government or by a person or body performing a public function, power, or duty. This means you should assume that all actions are subject to the Bill of Rights Act standard including legislation, regulations, policy development, service delivery, and programmes run by your agency (Ministry of Justice 2002: 16).

Human Rights Commission


In 1994 discrimination based on disability was deemed unlawful. This form of discrimination had not been included in the original act. ‘Disability’ is defined to include ‘psychiatric illness’, ‘psychological disability or impairment’ and ‘any other loss or abnormality of psychological, physiological, or anatomical structure of function’ (section 21(1)(h) of the Human Rights Act 1993).

The Commission’s roles and functions were redefined by the Human Rights Amendment Act 2001 to expand compliance with the Act to all government agencies and public bodies (as detailed in the above section), to direct the Commission to establish a national plan of action on human rights issues, and to emphasise the promotion of human rights and dispute resolution (rather than the investigation of complaints).
Primary functions of the Human Rights Commission

The Commission’s primary functions are:

(a) to advocate and promote respect for, and an understanding and appreciation of, human rights in New Zealand society; and

(b) to encourage the maintenance and development of harmonious relations between individuals and among the diverse groups in New Zealand society. (Section 5 of the Human Rights Act 1993).

To undertake these functions the Commission uses advocacy, promotes research, develops guidelines, coordinates human rights activities, undertakes human rights education, initiates inquiries, participates on human rights tribunals, reports to the Prime Minister on matters affecting human rights, and has the ability to receive complaints about possible breaches of the Human Rights Act.

In relation to mental illness, breaches of the Human Rights Act occur when a person is discriminated against because of their disability in:

- employment
- access to education
- access to public places, vehicles and facilities
- provision of goods and services
- land, housing and accommodation
- industrial and profession associations, qualifying bodies and vocational training bodies
- partnerships.

Since 2001 discrimination by government agencies and public bodies has also been prohibited. In addition, protection against discrimination applies whether a person has, has had, or is believed to have, a mental illness. It is also unlawful to discriminate against relatives or associates of a person because of that person’s mental illness.

Disputes resolution

The Human Rights Amendment Act 2001 emphasised the Commission’s role in promoting human rights. The Commission also has a role in mediating disputes, but no longer investigates disputes or forms opinions about whether a complaint under the Human Rights Act has substance.

A complainant may forward an unresolved complaint to the separate Office of Human Rights Proceedings where the Director of that office can decide how to proceed with the dispute. The Director may take the dispute to the Human Rights Review Tribunal, which has the power of a court with legally binding decisions. To date, there have been no mental health cases presented to the Human Rights Tribunal, so the effectiveness of this legal mechanism has yet to be tested. Furthermore, the Human Rights Commission receives a small proportion of complaints concerning discrimination on the basis of psychiatric disability (less than 7 percent in the year to June 2002).

Government accountability

A significant change introduced by the Human Rights Amendment Act 2001 was the incorporation of section 19 of the Bill of Rights Act into Part 1A of the Human Rights Act. This made the Government and public bodies accountable for discriminatory legislation, policies and practices, including those affecting mental health consumers.

If the Human Rights Tribunal finds a government agency or public body has discriminated, the agency may be subject to the same penalties as any citizen (that is, a restraining order, an apology, damages or other compensation). When discrimination is mandated by legislation, the Tribunal may make a Declaration of Inconsistency, which must be reported to Parliament, so the decision whether to change legislation or confirm its intention to discriminate falls back to the democratic process (Lindberg, 2002: 41).

The Associate Minister of Justice has also announced that the Government, in principle, will use the Bill of Rights Act as the anti-discrimination standard for itself. Employment law and related issues, such as sexual harassment, will continue to be covered by the Human Rights Act (Hunt 2001). All other government activity including legislation, policies and practices will be subject to the Bill of Rights Act anti-discrimination standard, with all complaints of discrimination initially going to the Human Rights Commission.

However, human rights law is not absolute. Rights are subject to ‘reasonable limits’ under section 5 of the Bill of Rights Act, so individual rights may be balanced against other considerations, when this is reasonable. Part II of the Human Rights Act provides for disability-related exceptions in different circumstances (for example, it is lawful to discriminate against a mental health consumer when selecting a flatmate).
Moreover, the Bill of Rights Act can be overridden in certain circumstances. For example, it is a person’s right to refuse medical treatment, but this right can be overridden if a person is committed under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Nevertheless, the court has emphasised that in exercising a relevant statutory discretion ‘a weather eye to the internationally recognised norms for the human rights’ should be maintained (Brookbanks 1996).

International human rights instruments


The New Zealand Human Rights Commission maintains oversight of New Zealand’s compliance with international instruments on human rights. In a report to the Prime Minister, the Commission clarified the application of international instruments in relation to mental health issues, stating:

International instruments on human rights set the standards by which all people should be permitted to live. The ideal standards for treatment of mentally ill people are delineated in a number of them. Although the Commission acknowledges that conforming with all the principles laid down in the instruments is difficult ... attempts should be made to meet the criteria outlined. (Human Rights Commission 1992: 59)

The five international instruments that relate to mental health are the:
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Declaration of the Rights of Disabled Persons
- United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

The International Covenant on Civil and Political Rights recognises the right of individuals to:
- freedom from cruel, inhumane or degrading treatment
- liberty and security
- freedom from arbitrary detention
- humane treatment and respect for a person’s inherent dignity if deprived of liberty
- freedom of information.

New Zealand ratified this covenant in 1978. Its principles are largely incorporated into the Bill of Rights Act.

Complaints about breaches of this covenant may be made to the Human Rights Committee of the United Nations, established under the covenant. New Zealand periodically reports on its compliance with this covenant to the Human Rights Committee.

The International Covenant on Economic, Social and Cultural Rights (article 12) states, ‘The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’

New Zealand ratified this covenant in 1978, with a reservation, so it has not been incorporated into New Zealand domestic law. The Government periodically reports on its compliance with this convention to the UN Committee on Economic, Social and Cultural Rights.

The Declaration of the Rights of Disabled Persons recognises a person’s right:
- to any necessary treatment, rehabilitation, education, training and other services to develop their skills and capabilities to the maximum
- not to be subjected to more restrictive conditions of residence than necessary.

This declaration is non-binding on United Nations member states.

The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (principle 1, subpoints 1–5), detail fundamental freedoms and basic rights, including:
- the right to the best available mental health care
- the right to be treated with humanity and respect
- the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment
• freedom from discrimination on the grounds of mental illness
• the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and other relevant declarations, such as the Body Principles for the Protection of All Persons Under any Form of Imprisonment.

These principles are non-binding.

In any dispute involving mental health issues, the Human Rights Commission can seek guidance from domestic legislation, international instruments and case law. Legally binding decisions on disputes can be made through only the Human Rights Tribunal using the litigation process.

**New Zealand Action Plan for Human Rights**

The development of a New Zealand Action Plan for Human Rights (NZAPHR) was included as a new function for the Commission by the Human Rights Amendment Act 2001.

The objectives of the NZAPHR include (Human Rights Commission 2002):

• mainstreaming the protection and promotion of human rights in society
• promoting the incorporation of human rights considerations into legislative and policy development
• enhancing compliance with international human rights covenants and conventions
• enhancing and promoting cooperation among government agencies as well as national institutions, NGOs, local organisations and other representatives of civil society
• paying greater attention to particularly vulnerable groups in society and ensuring effective steps are taken to address their situation
• incorporating human rights education as part of the plan.

The mental health sector was represented on the NZAPHR National Advisory Council and mental health issues were researched for the initial project in the development of the Action Plan, a major stocktake of human rights in New Zealand, *Human Rights in New Zealand Today*, published in September 2004 (Human Rights Commission 2004a, 2004b).

The stocktake referred to mental health issues mostly in three sections, and organised conclusions around the themes of “where New Zealand does well” and “where we need to do better”. The most significant points were:

- in relation to *The Rights of Disabled People*, where we do well includes: our human rights laws and frameworks, social awareness of disability in terms of human rights, the Disability Strategy, having an Office of Disability Issues and increasing participation in employment and education. Where we need to improve is in that there is not yet an International Convention on the Rights of Disabled People, disability could feature more strongly in existing human rights frameworks; disability is incorporated in a fragmented way in public sector day-to-day operations; data is inadequate; the Disability Strategy needs stronger implementation; more needs to be done in relation to employment, education and participation in decision-making; and there is a lack of oversight in relation to care and treatment for disabled people living in institutionalised settings.

- in relation to *The Rights of People who are Detained* under mental health legislation, where we do well is in having legislation and regulations that “have been developed with a regard to the requirements of international human rights standards” (HRC 2004b, 55); and having the external audit roles of the Commissioner for Health and Disability, and District Inspectors. Where we need to do better (to quote the report in full) is:
  - The data indicate that many service users are held for lengthy periods in conditions where they have limited freedom of movement, are isolated from others and are subject to sensory deprivation
  - It appears that restraint, seclusion and other practices limiting freedoms are, at times, being used in ways that are inappropriate under human rights standards
  - Some facilities do not meet national standards, or provide substandard levels of facilities or service, and as a result service user rights may be compromised
  - Workforce development and training concerns have been noted in a number of contexts
There are moral, ethical and legal concerns surrounding all forms of compulsory assessment and treatment (p.55).

in relation to The Right to Health, one of the points about where we need to do better is that children and young people with mental illness are one of the specific population groups for whom services are inadequate, as are refugees with high and complex needs.

Informed by this stocktake, the Action Plan will be developed in the latter half of 2004.

**Human rights education**

The Human Rights Amendment Act 2001 resulted in the Commission’s focus shifting from handling complaints to human rights promotion. Tu Tikanga Now! was a human rights training programme run by the Commission for people with disabilities, using a grassroots model aimed at empowering disabled people to educate each other (Human Rights Commission, 2003). Working alongside Like Minds, the Commission has developed a training workshop and resource on human rights for people who experience mental illness. Korowai Whaimana (HRC, 2004) was developed by Goldsack Consulting, a service user consultancy, and extensively critiqued by the Like Minds National Advisory Group and others within the service user movement, in order to develop a resource and training workshop specific to the needs of service users in relation to their rights. The first group of Korowai Whaimana trainers are from the northern North Island and are currently offering free workshops to service users/tangata whaiora within that region. There is to be further training of Korowai Whaimana educators for the lower North Island and the South Island with an aim to have approximately 40 nationwide educators offering free workshops by mid 2005 (Human Rights Commission, 2004c).

**Discussion**

Clearly, the Human Rights Commission’s roles and functions are extensive. The Human Rights Amendment Act 2001 resulted in the Commission’s focus shifting from handling complaints to human rights promotion. At the same time, the Commission maintains its role in protecting New Zealanders from unlawful discrimination by providing legal expertise and litigation capacity for resolution through the Human Rights Tribunal. Not surprisingly, the Commission took a significant role in intervening in district planning issues in Manukau and Hamilton in relation to supported accommodation for mental health consumers. The greater emphasis on international human rights instruments is also indicative of the Commission’s increasing role as New Zealand’s watchdog on discrimination issues.

With its legislative authority, the Commission provides the framework for the protection of human rights and prevention of discrimination in New Zealand. The Commission addresses discriminatory practices by providing legislative protection for individuals and by promoting the idea that all individuals have the right to self-determination. The Commission does not provide detailed guidance on how and why discrimination or stigmatisation occurs. It understands discrimination from within a clearly defined human rights framework. It is through coordinating and working with other agencies, such as the Health and Disability Commissioner’s Office, Mental Health Commission and Like Minds project that these gaps can be filled. The Human Rights Commission’s ability to take complaints to the Human Rights Tribunal and the Tribunal’s ability in turn to make Declarations of Inconsistency about legislation provide significant anti-discrimination muscle. A Declaration of Inconsistency could lead to a change in existing or proposed legislation. For mental health consumers, this provides a mechanism to challenge legislation they perceive as discriminatory. The Tribunal has not yet made a declaration, so it is too early to know how this would work in practice.

The Commission deals with discrimination issues at many levels, from individual complaints to broader coalitions with stakeholders concerned with discriminatory attitudes embedded within the community, to particular organisations’ formal practices or intentions.

In an interview for this project, a Human Rights Commissioner expressed concern about the duplication of anti-discrimination activities. The Commission is attempting to ensure it does not take up complaints from mental health consumers that should be more effectively and properly dealt with through other forums, such as the Health and Disability Commissioner.

Although the Human Rights Commission is driven by a human rights philosophy, the language used in its documents indicates an understanding and utilisation of public health and disability inclusion philosophies. The avenue of rules, regulations and international covenants and the vehicles of advocacy, education, legal reform and policy are the means by which the Commission attempts to protect New Zealanders from unlawful discrimination.
Office of the Health and Disability Commissioner

The Health and Disability Commissioner Act 1994 (HDC Act) created the Office of the Health and Disability Commissioner to promote and protect the rights of health and disability services consumers by:

- appointing a Commissioner to:
  - investigate complaints against people or bodies who provide health care or disability services
  - promote, by education and publicity, respect for the rights of health consumers and disability services consumers
  - make public statements and publish reports about anything affecting the rights of health consumers or disability services consumers (see section 14 of the HDC Act for the full list of powers and functions)
- establishing consumer advocacy services
- announcing a Code of Health and Disability Services Consumers’ Rights (the Code).

The Code was published in July 1996 and describes health consumers’ rights in terms of broad principles that should govern the delivery of services. All health and disability service providers are covered by the Code, including paid and unpaid services, hospitals, individuals such as psychiatrists or psychologists, caregivers and even people who care for family members.

The Code sets out 10 rights, including the right to:

- be treated with respect
- be free from discrimination or exploitation
- dignity and independence
- services of an appropriate standard
- give informed consent
- complain.

The complaint mechanisms under the HDC Act are the primary vehicle for dealing with complaints against health and disability services.

The Code applies to all mental health service users, including people under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH (CAT) Act), and the relationship between the Code and the Act can be complex. For example, although the Code promotes the principle of informed consent, it does not override the MH (CAT) Act, which allows for a person to be committed to compulsory assessment and treatment in certain circumstances. Accordingly, the Commissioner is limited by the MH (CAT) Act in considering complaints about the impact of compulsory assessment and treatment and has on the principle of informed consent, despite the Code. However, the MH (CAT) Act does not prevent the Commissioner from considering complaints alleging a breach of any other Code right, including a complaint about the quality of clinical services provided.

Complaints can be addressed in several ways. The Commissioner can decide to:

- Investigate the complaint (under section 36 of the HDC Act)
- Refer the complaint to an advocate (under section 36 of the HDC Act)
- Take no action (under section 37 of the HDC Act)
- Consult with, and refer the matter to, an appropriate health professional body (under section 38 of the HDC Act). (This may occur when the complaint raises issues of professionalism and professional competence, rather than clinical competence).

Many complaints can be resolved with the assistance of advocates. Unresolved complaints can be referred to the Commissioner, who may decide to investigate. Investigations can take up to two years and result in Commissioner’s recommendations, which are often an apology and/or a change of practice or policy at a local or national level. In more serious cases, the Commissioner can refer the complaint to the Director of Proceedings, who can instigate proceedings in a disciplinary tribunal, the Human Rights Review Tribunal or a court.

Recommendations or a referral to the Director will be considered and/or made only when, following an investigation, the Commissioner has determined there has been a breach of the Code. If the Code has not been breached, the Commissioner cannot refer the matter to the Director and usually will not make recommendations. The Commissioner can also refer complaints to other agencies such as the Human Rights Commission if appropriate.

In terms of anti-discrimination measures in mental health, the Commissioner has a highly focused and legally prescriptive role, which is constrained by the MH(CAT) Act. Indeed, the Office sees itself as ‘hamstrung by the limited options to address complaints … and the lack of “teeth” to ensure
recommendations are implemented’ (Health and Disability Commissioner, 2002). (Note also that the Amendment Act to come into force in September 2004 will allow more flexible complaint-handling procedures.)

The Office acts as a watchdog agency, informing individuals and organisations of their obligations and rights under the Code. Although mainly driven by the complaints process, the Office activity promotes the Code through a variety of media to diverse groups. The ability of the Commissioner to assess and recommend operational and/or policy changes to prevent breaches of the Code means this agency can be involved in the ‘how’ and ‘why’ of discrimination. Its inability to enforce its recommendations is, however, a concern.

The Office of the Ombudsman

A major role of this office is to ‘investigate complaints received from members of the public who feel they have been treated unfairly by some act, omission, decision or recommendation of a central or local government organisation.’ (www.ombudsmen.govt.nz). Included in their legislation is the authority to ‘form an opinion whether the act, omission, decision complained of was inappropriate on any of a number of grounds. These grounds include discrimination. Specifically, that the act, omission or decision was ‘unreasonable, unjust, oppressive or improperly discriminatory’ or that it ‘was in accordance with a rule of law or a practice that is or may be unreasonable, unjust, oppressive or improperly discriminatory.’

The Office also has responsibilities in relation to the Official Information Act and to the Protected Disclosures Act, both of which can have relevance to the rights of mental health service users.

The Ombudsmen’s Office is an ‘office of last resort’. In matters relating to complaints of an administrative kind, eg, the delivery of services, the Ombudsmen will generally require a complainant to have first tried to resolve the complaint directly with the agency concerned (except under the Protected Disclosures legislation). If, after trying to resolve the complaint, the complainant remains dissatisfied then an Ombudsman can be asked to review the matter. Further, where an agency has been specifically established to consider complaints, the office will refer on. For example, a complaint made to Ombudsmen about infringements of rights in mental health services is likely to be referred to the Health and Disability Commissioner. However, an Ombudsman can review a Health and Disability investigation.

Most investigations undertaken by an Ombudsman are resolved during the course of investigation and few proceed to a formal recommendation being made. Where an Ombudsman makes a formal recommendation most often the agency concerned accepts the recommendation. In matters relating to the release of official information there need only be a decision by an agency to decline in part or full the release of the requested information before an Ombudsman investigation can be initiated. The Ombudsmen are not able to compel agencies to accept their recommendations but they can report to Parliament on them.

The Ombudsmen’s Office website also has a useful list of ‘alternative remedies’, ie, other agencies which can deal with complaints – which could include mental health discrimination. The list includes the Banking Ombudsman, the Broadcasting Standards Authority, the Privacy Commissioner, the Medical Council of New Zealand and the New Zealand Press Council. It is beyond the capacity of this stocktake to describe the roles and functions of all agencies whose function includes providing remedies for discrimination. The important thing to note is that discrimination against people with experience of mental illness can occur in a wide variety of areas of public life, as the Like Minds Discrimination Survey shows – and likewise, there are many avenues for redress.
DISABILITY SECTOR

Office for Disability Issues

The key government player in the disability sector in relation to anti-discrimination activities is the Office for Disability Issues. It was established in July 2002 as a semi-autonomous agency administered by the Ministry of Social Development. The Office’s three key responsibilities are to:

- Promote and monitor the implementation of the New Zealand Disability Strategy in government and wider society.
- Provide policy advice on disability issues, including:
  - Leading strategic policy development regarding disability issues across the whole of government
  - Maintaining an overview and providing input to policy affecting people with disabilities
  - Contributing a disability perspective to policy development led by other government agencies.
  - Working with other agencies to provide advice and meet formal international obligations related to disability issues.
- Provide services to support the Minister for Disability Issues in his or her advocacy role (www.odi.govt.nz/about/what-we-do.html).

The Office has a cross-sectoral focus, guided by the New Zealand Disability Strategy (Minister for Disability Issues 2001). The strategy provides a long-term plan for removing the barriers that face people with disabilities.

The Strategy’s vision is of a society based on the human rights, empowerment and participation of all New Zealanders and of a society that values and celebrates diversity and recognises the principles of the Treaty of Waitangi. Its primary focus is on what government departments and other publicly funded organisations need to do to remove barriers that face people with disabilities. (Minister for Disability Issues 2002: iii)

The initial focus of strategy implementation and the Office’s work is on government activity. It is assumed that government should lead by example, so wider society will follow suit and result in realisation of the strategy’s vision. The strategy can be seen as an anti-discrimination framework that covers people who experience disability associated with impairment – including mental health-related disability.

The strategy outlines 15 objectives with a series of actions under each, including:

- encouraging and educating for a non-disabling society by using anti-discrimination programmes
- enforcing disabled people’s rights and providing information on rights, ways to recognise discrimination and how to self-advocate
- providing greater employment opportunities, including educating employers about disabilities.

Also included in the actions are specific anti-discrimination measures such as ensuring disability services do not perpetuate the myth of disability as an illness and ensuring discrimination-free access to health services.

The Office works to ensure the strategy is understood and accepted by the people who will implement it and reports annually on progress to Parliament.

Through its work, the Office has developed relationships with all government agencies, particularly the Ministry of Health, Ministry of Social Development, Ministry of Education, Department of Labour, Accident Compensation Corporation, Human Rights Commission, Office of the Disability Commissioner and Mental Health Commission. These relationships are important, because the strategy was intended to work alongside existing frameworks and functions, such as the human rights legislation and the complaints role of the Health and Disability Commissioner.

The Office’s driving philosophy is one of disability inclusion in a society that, intentionally or unintentionally, discriminates against people with impairments. ‘Disability’ is a process that occurs when:

one group of people create[s] barriers by designing a world only for their way of living, taking no account of the impairments other people have … Disability relates to the interaction between the person with the impairment and the environment. It has a lot to do with discrimination. (Minister for Disability Issues 2001: 3)
This all-encompassing perspective defines the Office’s intention but not its role. The Office intends to implement the strategy through the public sector, and through key relationships encourage New Zealand society to be more tolerant of disabled people. The Office’s role is to achieve this using advocacy, education and policy development.

The Office is responsible for addressing discrimination where it affects people’s access to services, well-being and participation. It has developed a framework for addressing and monitoring a broad range of disability issues in society, including discrimination. It has also provided central government agencies with information about the way in which they may report to Cabinet about the impact of policy developments on the disability sector.

While the Office notes that people with experience of mental illness are seen as part of the disability sector, this does not always sit comfortably with mental health service consumers. This issue is shared with other groups, for example, the deaf community, who find the historic use of the term disability to be very negative.

Mental illness is brought into the disability framework when the ‘impairment’ of mental illness is seen to limit a person’s full potential through society’s lack of understanding. Within this framework, physical, sensory, intellectual, neurological and psychiatric impairments are comparable, so the means of combating discrimination against such impairments is understood to be similar. The philosophy of disability inclusion is potentially powerful in that it can unite a seemingly disparate group of individuals. It does, however, have the potential to minimise the uniqueness of people who experience mental illness, which could undercut service user movement values. Also, some service users do not feel comfortable with the concept of ‘impairment’.

The Office undertakes a number of general anti-discrimination activities targeting disability sector issues, including those affecting people with mental illness.

OTHER GOVERNMENT AGENCIES

Government agencies other than those with central responsibility for mental health, public health, human rights and disability also play important roles in anti-discrimination work. Their roles range right across government and their initiatives include employment assistance programmes, suicide prevention programmes and curriculum development on mental health. The list of initiatives below is not exhaustive; it is intended only to provide a glimpse of what other central government agencies are doing to combat mental illness discrimination. It also demonstrates the diversity of approaches that can be used, and the inter-agency nature of much of this work. Many of the initiatives are fundamentally informed by the New Zealand Disability Strategy.

Mental health anti-discrimination activities are less pervasive among organisations for which mental health service consumers are only one section of a targeted population. Also, the range of activities and relevance to mental health anti-discrimination is highly variable.

State Services Commission

The States Services Commissioner is responsible for overseeing the public service, assessing departments’ performance and allocating responsibilities between departments. As such, the State Services Commission (SSC) takes on a public service leadership role, which has been demonstrated through its leadership in equal employment opportunities (EEO) and its administration of the Mainstream Programme, which facilitates employment opportunities in the state sector for people with significant disabilities.

Equal employment opportunities

Each chief executive in the public service is required to develop an annual EEO Programme for their department and to report on EEO progress for the past year (section 58 of the State Sector Act 1988).

The SSC is required to ‘promote, develop and monitor EEO policies and programmes for the Public Service’ (section 6 of the State Sector Act 1988). The State Sector Act 1988 recognises ‘persons with disabilities’ as one of the groups for EEO attention (section 56(2)(h)).

Departments develop their EEO policies and programmes under the auspices of EEO Policy to 2010: Future Directions of EEO in the New Zealand Public Service (State Services Commission 1997).
EEO in the public service is based on the application of the merit principle and focuses on removing unfair discriminatory practices and building inclusive systems and structures that promote equal opportunities in the workplace.

**Mainstream programme**

The SSC administers the Mainstream programme, which is a two-year, subsidised employment programme for people with significant disabilities. Placements are created only within state sector organisations, not the private sector.

Mainstream’s overall objective is to provide opportunities for people with significant disabilities to gain meaningful, long-term employment and to increase the diversity of the state sector workforce.

Mainstream provides the funding for other organisations to create positions and is helped by a range of placement specialists from organisations such as Workbridge, which works with employers to match the right person to the job.

The programme provides:

- a 100 percent salary subsidy for the first 12 months of employment
- a 50 percent salary subsidy for the second year of employment
- access to $1,500 for external training to both the Mainstream participant and their direct supervisor.

The programme adheres to principles contained within a good practice model for equitable supported employment, including:

- placement first, followed by on-the-job training and support
- ongoing support
- equitable financial remuneration
- universal eligibility
- integrated settings
- career development (for example, extra training).

**Affirmative action**

The Mainstream programme can be seen as affirmative action and in line with the New Zealand Disability Strategy. It focuses on the Government showing how to overcome discrimination. A central premise underlying affirmative action in this context is that over time, the workforce will reflect the diversity of the population, including the one in five New Zealanders who experience mental illness.

Affirmative action is outcome-focused with unclear understandings of the anti-discrimination processes it seeks to mitigate. For example, affirmative action internalises the contact thesis, which suggests the more contact we have with ‘disabled’ persons, the less discriminatory we will become, first in the workplace and then in society more generally.

Not clearly articulated within such programmes is the impact of disability disclosure for the affirmative action candidate. They are forced to confront their ‘disability’ and acknowledge possession of it to get the benefits of inclusion in such programmes.

The Mainstream Programme is underpinned by a disability inclusion philosophy and attempts to influence attitudes and behaviour in the public sector.

**Ministry of Youth Development**

In 1998, with Te Puni Kokiri and the Ministry of Health, the Ministry of Youth Affairs (now the Ministry of Youth Development) launched the New Zealand Youth Suicide Prevention Strategy. In 2001, the then Ministry of Youth Affairs took responsibility for leading and co-ordinating the strategy.

Goal one, Promoting Wellbeing, calls for mental health promotion and well-being as well as initiatives to reduce the stigma of mental illness, given the relationship between suicide and mental illness. The strategy is multifaceted involving the media, schools, primary health care providers, Child Youth and Family workers, mental health services and hospital emergency departments. An initial qualitative evaluation of the strategy in 2003 found the strategy well received by all involved, but was inconclusive about its effectiveness.

Underpinned by a public health approach, the strategy adopts many traditional aspects of health promotion, such as education programmes in schools and community development work.

The Ministry of Youth Development and Ministry of Health are developing a Youth Health Strategy, which will include further development of intersectoral work to reduce youth suicide and mental health programmes that focus on wellness (Ministry of Health 2003b: 31).
Pathways to Inclusion: Nga ara whakauru ki te iwi whanui: Improving vocational services for people with disabilities is a directional document that resulted from the Department of Work and Income’s (DWI’s) review of vocational services (Associate Minister of Social Services and Employment 2001). It aligns with the New Zealand Disability Strategy, seeking to ‘provide opportunities in employment and economic development for disabled people enabling them ‘to work in the open labour market (in accordance with human rights principles) and maintain an adequate income’ (Associate Minister of Social Services and Employment 2001: 7).

Pathways to Inclusion includes initiatives such as the repeal of the Disabled Persons Employment Promotions Act 1960, which exempts employers of people with disabilities in sheltered workplaces from minimum wage and holidays legislation. (This legislation is being phased out over five years from 2002.) It also provides for the review of Part 3 of the Disabled Persons Community Welfare Act 1975, which provides for funding for vocational services. Other initiatives include a greater focus on paid work, enhancing community participation for people with disabilities, and building sector capacity by widening DWI’s role (for example, to conduct research and evaluation and workforce development).

Pathways to Inclusion is clearly underpinned by human rights and disability inclusion ideals and can be seen as a vocational anti-discrimination document. This intention is clearly spelt out in the Minister’s foreword:

our efforts will only succeed if there is a mindshift at all levels – among communities, employers, service providers, families/whānau and people with disabilities themselves … The challenge for us all is to stop judging people for what they can’t do, and start valuing what they can do. (Associate Minister of Social Services and Employment 2001: 5)

Ministry of Education

Mental health promotion as part of the health curriculum is supported by the Ministry of Education through professional development, such as the student well-being contract and the provision of teacher resources. Health promotion is one of the underlying concepts of health and physical education in the New Zealand curriculum, as is hauora, a Māori concept of well-being, of which mental health is a critical component. In the Curriculum in Action series, Everybody Belongs (Ministry of Education 2000) for teachers of students in their 4th-6th school years, the focus is on mental health with a variety of outcomes including:

Creating mentally and emotionally safe environments in which all people work towards eliminating judgments, assumptions, and discrimination based on stereotypes, promoting the tolerance of difference, and reducing the hurt caused by remarks about … difference, even those made in fun. (www.tki.org.nz)

This particular resource suggests learning opportunities to develop students’:

knowledge, understandings, and skills to examine discrimination and stereotyping, and to evaluate their impact on people’s mental health for example, when recognising instances of discrimination and stereotyping, acknowledging individual differences, respecting the rights of other people, and responding constructively to discriminatory practices and behaviours. (Ministry of Education 2003)

This type of approach concentrates on the formal educational environment to create an understanding about discrimination. School programmes of this nature may serve to create a culture of understanding, the effects of which may become visible in years to come. They may also contribute to understanding of family members and peers with mental health issues.

The extent to which anti-discrimination activities are integrated into the school curriculum is unclear. An interview with a former Mental Health Commission commissioner enabled her to reflect on her current organisation’s (Group Special Education in the Ministry of Education) service delivery to children and young people with special needs, some of whom will have mental health problems.

Generalising from that reflection on the experience of Group Special Education, mental health anti-
discrimination activities may be less pervasive among organisations for which mental health service consumers are only one (small) section of the organisation’s total targeted population. Group Special Education is beginning to act on what it believes to be widespread exclusionary attitudes and behaviours within schools towards people with mental illness. This involves combining mental health promotion and a programme to reintegrate children with serious mental illness into mainstream schools.

Creative New Zealand (Arts Council of New Zealand Toi Aotearoa)

Creative New Zealand (Arts Council of New Zealand Toi Aotearoa) is a government agency and a major source of arts funding in New Zealand. It administers contestable funding that is distributed on the basis of artistic merit, with separate mechanisms for delivering Māori and Pacific funding to ensure a special recognition of the arts of those populations.

One of Creative New Zealand’s legislative functions is to ‘encourage, promote, and support the arts … of the diverse cultures of New Zealand’ (section 7(1)(d) of the Arts Council of New Zealand Toi Aotearoa Act 1994). There is debate around the idea that cultural diversity does not imply only ethnic diversity, but may refer to other communities of interest. Potentially this could be interpreted to include communities identifying around the experience of mental illness, for example, mental health consumers.

Creative New Zealand’s foundation legislation requires it to encourage participation in and access to the arts. This is the reason for its recurrent funding to Arts Access Aotearoa, an organisation encouraging ‘people and communities with limited access to the arts’, including people with psychiatric disabilities (Eames 2003: 97).

Office of Film and Literature Classification

Another function of government relevant to the anti-discrimination work in mental health is censorship. Curtailing freedom of expression may be seen as antithetical to artistic endeavours, but censorship does impinge on certain forms of artistic expression. Although censorship in the arts has usually focused on certain depictions of sexuality and violence, more recently there have been debates around the censorship of ‘hate speech’, that is, discriminatory portrayals of minorities that incite hatred.

The Films, Videos and Publications Classification Act 1993 governs the Office of Film and Literature Classification. Publications (which includes films, videos, computer games, sound recordings and so on) can be prohibited or restricted if they are deemed ‘objectionable’, that is, ‘likely to be injurious to the public good’. In determining whether a publication is objectionable, various factors should be taken into account, including the way in which it:

(e) Represents (whether directly or by implication) that members of any particular class of the public are inherently inferior to other members of the public by reason of any characteristic of members of that class, being a characteristic that is a prohibited ground of discrimination specified in section 21(1) of the Human Rights Act 1993. (Section 3 of the Films Videos and Publications Classification Act 1993)

The Human Rights Act 1993 prohibits discrimination against people on the grounds of psychiatric illness. Therefore, a publication that represents people with psychiatric illness as ‘inherently inferior to other members of the public’ has the potential to be judged objectionable.

Very few publications have been prohibited or restricted using these grounds, but one notable instance was when two videos from Living Word distributors, dealing with gay rights and Aids, were deemed objectionable. The distributors successfully appealed the decision, with the Court of Appeal emphasising that it was ‘not sufficient to consider a publication objectionable if all that is being expressed is opinion’; it had to be a depiction that was objectionable (Government Administration Committee. 2003: 15).

The parliamentary committee considering the implications of the Court of Appeal decision, expressed concerns about limiting the capacity of the Office of Film and Literature Classification to ‘respond to social change within our society, for example, in relation to those matters listed in section 21 of the Human Rights Act’ (Government Administration Committee. 2003: 15: 21).

However, appeal provisions were successfully used by a group from the mental health sector to complain about the classification of the film Me, Myself and Irene (Farrelly and Farrelly 2000), which was seen as conveying discriminatory attitudes towards schizophrenia. The complaint was successful, at least on one level, with the age restriction being raised.
This final section of our chapter on the role of central government in anti-discrimination activities singled out several government departments and agencies for attention, in order to highlight the variety of ways in which the work of disparate government agencies can include anti-discrimination.

As a whole, this chapter has shown how extensive a mandate there is, and what a wide range of activities relating to mental health anti-discrimination occur, throughout central government. The sectors dealing with mental health, public health, human rights and disability play leading roles, and a variety of other agencies make important contributions.
National Professional and Mental Health Non-Government Organisations

PROFESSIONAL ORGANISATIONS

Professional organisations whose members work in the mental health sector, such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and the New Zealand Psychological Society do not yet take any significant role in the New Zealand anti-discrimination sector.

Professional bodies emphasise the development of internal policy (that is, policy directed towards members of the professional body) and competencies for good clinical practice. They also sometimes turn their attention to wider health and social issues, and it is in this context that professional bodies in some other countries, such as the United Kingdom and the United States, have been involved in anti-discrimination.

For example, British psychiatrists lead an anti-discrimination campaign. Changing Minds is driven by the Royal College of Psychiatrists, Royal College of Physicians of London and British Medical Association. It focuses on eliminating discrimination within the medical profession, because medical practitioners are seen as the frontline ‘when helping people with mental disorders’ (Royal College of Psychiatrists, Royal College of Physicians of London and British Medical Association 2001: 5).

The RANZCP Policy on Mental Health Services provides a window of opportunity for anti-discrimination work. It sets out a framework for promoting mental health and preventing mental illness, minimising the effects of mental ill health on families, service users and communities, and assuring service users’ rights (RANZCP 1997). The policy outlines three principles for mitigating the effects of discrimination (RANZCP 1997: 3, 10):

- ‘The rights of people with mental disorders should be assured’ (principle 12).
- ‘The stigma attached to those with mental disorder, their carers and mental health workers should be addressed and rectified’ (principle 13), with an acknowledgement that ‘stigma … has led to … isolation in the community, … discrimination … problems of access to services [and] inadequate resourcing of mental health services’. The RANZCP sees possible solutions in public education programmes and the codification of rights (perhaps a mental health version of The Code of Health and Disability Services Consumers’ Rights as produced by the Health and Disability Commissioner).
- ‘Affirmative action is required to redress situations where people with mental disorder have not been treated equitably by government and non-government agencies’ (principle 14).

Principle 15 also touches on anti-discrimination, but from a health promotion perspective (RANZCP 1997: 11):

- ‘Prevention and early intervention strategies should have a high priority’, where ‘disseminating information on the types and effects of mental disorder, its prevalence in the community, treatment methods and prevention’ should be encouraged.

Within these four principles lies RANZCP’s general perspective on anti-discrimination. In contrast to UK professional bodies, which focus heavily on discrimination within mental health services generally and of medical practitioners specifically, RANZCP adopts a less focused approach. The UK perspective is to eliminate discrimination within mental health services because of its acknowledged negative effects on service users. The RANZCP approach is to eliminate discrimination within general society, because this negatively affects service users and mental health practitioners. The former approach
mitigates discrimination from the inside out, the latter mitigates from the outside in.

Clearly underpinned by a medical model philosophy, although human rights and public health approaches are incorporated into its perspective, the RANZCP promotes several avenues for change, including the rules and regulations that guide mental health practice, community understandings of mental illness, and the ways mental illness is spoken about.

A different view of anti-discrimination is adopted by the ANZCMHN, which outlines anti-discrimination outcomes in *Competencies for Advanced Practice in Psychiatric Mental Health Nursing in New Zealand* (ANZCMHN 1995). Zero tolerance of discrimination in interactions with service users, families and associates is a key competency measure. No mention, however, is made of how discrimination can be mitigated. The *Standards of Practice for Mental Health Nursing in New Zealand* do not mention anti-discrimination directly, but do discuss respect for the rights of consumers and the promotion of health and wellness within the context of practice (ANZCMHN 1995). This could be identified as a health promotion approach to anti-discrimination, similar to that outlined in the Ottawa Charter for Health Promotion (WHO 1986).

The New Zealand Psychological Society is the main professional organisation of psychologists. The Society undertakes a number of tasks that could potentially include anti-discrimination, such as professional support and development to members and occasional commentary on social issues. However, this is not an area of focus for the Society, although at its national conferences research on stigma and discrimination is sometimes presented. In a positive step, this year the Society overturned a discriminatory rule that meant removal of anyone from the executive if they came under the Mental Health Act.

**NATIONAL MENTAL HEALTH NON-GOVERNMENT ORGANISATIONS**

National NGOs have wide coverage and focus on a broad range of issues. They can coordinate, promote, educate, advocate and/or provide services that assist mental health consumers. Few national NGOs organise their activities around anti-discrimination, but many contribute to anti-discrimination and destigmatisation in the course of their work.

The Mental Health Foundation, for example, has mental health promotion as its main focus. Its mission is “to improve the mental health of all people and communities in New Zealand” (www.mentalhealth.org.nz) and its web page says that it “values the expertise of mental health consumers tangata whai ora”. In relation to anti-discrimination, the Foundation tends not to initiate specific projects on its own account, but it is a major provider to the Like Minds project, with involvement in projects that include the government policy project and Speakers’ Bureau.

The Mental Health Foundation also facilitates the Mental Health Advocacy Coalition (MHAC), a group representing a range of mental health organisations that provides commentary on mental health issues, including discrimination.

Platform is a national organisation that gives a voice to mental health sector NGO organisations providing community services. It has provided support to anti-discrimination initiatives through a number of its projects, including Standards in Action, which assists NGOs in preparing to meet the National Mental Health Sector Standards (which include the anti-discrimination standard).

Training needs in mental health, particularly in NGOs, led to the development of Blueprint, an initiative of Pathways Trust. Blueprint is an organisation that delivers the National Certificate in Mental Health Support Work, a 40-week programme covering personal development, cultural issues, consumer-centred practice and legislation; an Essential Skills Programme, which covers a range of areas including the history of mental illness and recovery principles and competencies (which includes information about stigma and discrimination).

Some national organisations focus on particular mental illness conditions.
Schizophrenia Fellowship New Zealand (Supporting Families) is a national NGO that provides support, education, advocacy and information, and is particularly focused on families and caregivers. It works on public education, providing information to schools, government agencies, employers and educational institutions about mental illness. Their charter includes a call for action “to end stigma and discrimination against people with a mental illness, through improved education of the general community and health professionals, legislation and more accurate and responsible representation in print and electronic media” (www.sfnat.org.nz). Specific activities include coordinating the Novartis AstraZeneca Schizophrenia Art Awards, which are aimed at supporting artists with experience of schizophrenia and educating New Zealanders about the condition, and supporting Schizophrenia Awareness Week to raise public awareness.

Balance, a national bipolar and depression network established and operated by consumers to help members with mood disorder, uses a recovery framework. It acts as an umbrella group for regional bipolar support groups and facilitates workshops on self-management and recovery. Peer support processes are particularly effective at combating internalised stigma.

There is at present no national body representing service user organisations, though there was one from 1990-1998. Efforts have been made over the last few years to develop regional networks and a national network, and when these have developed so as to clearly represent service user and their groups and organisations, there is likely to be a strong impact on the leadership and direction of anti-discrimination work.

Overall, national professional bodies and national NGOs have an important role to play in the work of anti-discrimination; and in the future we can expect to see strong national leadership from service users.
Regional and Local Providers

INTRODUCTION
The regional and local providers discussed in this section conduct anti-discrimination activities outside the Like Minds project (Like Minds regional provision was discussed in Chapter One). These providers include mental health service providers such as DHBs and local NGOs, service user organisations and regional public health units.

MENTAL HEALTH SERVICE PROVIDERS
All publicly funded mental health service providers at the local level, whether DHB services or NGOs, need to meet Human Rights Act anti-discrimination obligations, just as central government does. They are also required to meet Standard 18 of the National Mental Health Standards.

Among mental health service providers, anti-discrimination activities can be divided into four broad types that tend to be integrated into the mainstream service delivery of the organisation:

- Work with mental health consumers involves actively supporting consumers to manage situations in which they might be subject to discriminatory practices. It involves providing self-awareness training to address internalised sigma and low self-expectations and others’ low expectations.

- Work with critical gatekeepers inside the mental health sector often involves including anti-discrimination messages in advocacy activities as well as training health professionals and workers about discriminatory practices and their effect on recovery.

- Work with critical gatekeepers who govern access to other sectors (housing, employment, government services and education) to reduce discriminatory attitudes and practices.

- Promoting non-discriminatory practices, attitudes and behaviours in the broader community by promoting anti-discriminatory messages with families and community groups and through the media.

District Health Board mental health services
District Health Boards are the major providers of specialised mental health services in New Zealand. Their Standard 18 requirements make them responsible for implementing processes that promote mental health and community acceptance of mental health consumers.

It was not possible to survey all the activities of all DHBs, so in this section a few select examples are given to demonstrate the kinds of activity that are undertaken.

The Canterbury DHB’s Project to Counter Discrimination within the Mental Health Division is one initiative. Outlined in a series of action strategies, Canterbury DHB has detailed plans for a variety of initiatives (for example, in-service training, Hearing Voices workshops, management plans for promoting non-discriminatory policy, employee selection and staff/consumer interaction training). Specific staff members are responsible for facilitating and implementing the project.

Other DHBs undertake anti-discrimination activities such as Hearing Voices, mental health awareness and anti-stigma workshops in schools and presentations to community groups. Service development (for example, Hutt DHB) and community consultation (for example, Southland DHB) are also activities undertaken.

Educating the wider community about mental health issues is an important role for DHBs because the delivery of mental health services now occurs mainly
within community settings, and it is of key importance that services such as supported housing initiatives are welcomed in neighbourhoods.

Aside from these formal programmes, providers of services for people with experience of mental illness appear to be undertaking a considerable amount of informal, ongoing anti-discrimination work in the course of their everyday service delivery. Much of the work involves assisting people to access mainstream services and addresses any discrimination issues along the way. These anti-discrimination activities take various forms such as advocacy, support, brokering, training and facilitation. The activities involve providers dealing with a wide range of public, private and not-for-profit organisations, including prospective employers, Housing New Zealand Corporation (HNZC) staff, real estate agents, general practitioners, Department of Work and Income (DWI) staff and budget advisors. In fact, it could be suggested that all interactions with service users and family members contain the potential for informal anti-discrimination work, through conveying respect, hope and support.

The “continuous quality improvement” emphasis of the Mental Health Standards lays the basis for the evaluation of anti-discrimination initiatives and working towards improvements over time. However, the Standards in practice do tend to emphasise meeting policy requirements rather than measuring activities and their outcomes.

It was the view of some of the interviewees for this project that mental health services were not integrating anti-discrimination approaches into their everyday practices, nor were they carrying out enough in the way of focused activities. It was noted that very strong imperatives such as crisis intervention drive their work and this may mitigate against anti-discrimination activity. It is a sad fact that anti-discrimination providers often see mental health services as an important target audience for their work.

It was also pointed out that most mental health services work within a medical model with a treatment focus; this model fits because it encourages people to come for treatment. However, anti-discrimination work should operate more widely across human rights, public health and other models (in fact Standard 18 has a strong human rights, public health and disability inclusion emphasis). To develop anti-discrimination activities further in DHBs requires a conscious shift away from the medical model and a realisation that with most mental health services now being delivered within communities, positive community attitudes are the key to their success. Moreover, in terms of treatment, antidiscriminatory attitudes assist service users and their families with the task of recovery.

Regional NGOs providing mental health services

These NGOs are primarily mental health service providers, funded through DHBs or central government agencies. The funding arrangements are important because they can determine whether NGOs are required to meet statutory obligations. For example, NGOs funded with mental health money (whether through a DHB or otherwise) to deliver services, such as primary or secondary mental health care, residential care, community support or employment services are required to meet the National Mental Health Standards. NGOs not receiving mental health money will be subject to the Standard only if their funding contract identifies the Standard as relevant to service delivery. Anti-discrimination, therefore, can be a statutory or contractual obligation.

It is evident there are several NGOs that engage in anti-discrimination work as part of their day-to-day activities. These NGOs tend not to be funded specifically to conduct this activity but do so because it is a part of their process of working with the wider community. For example, Temporary Solutions, an employment agency, negotiates employment for consumers. Using an anti-discrimination approach, it does not ‘sell’ consumers as ‘consumers’ but discusses potential employees’ abilities at an everyday level, ‘what skills does this person bring?’ and ‘how can we cater for their specific needs?’ Such questions are typical of any employment service negotiating contracts for their personnel. This type of work can be seen as invisible anti-discrimination work, and one could argue that anti-discrimination work at this level creates an immediate effect for both consumers and the wider public.

Another example is Pathways, which began in the Waikato region, providing accommodation and support services for mental health consumers. Activities contributing to anti-discrimination include:

- residential housing and home-based support, including a supported landlord bureau, for people with experience of mental illness with a duration of more than one year
- assistance to tenants to move into the mainstream rental market
• presentations and workshops with government agencies and other organisations (for example, Citizens Advice Bureaux)
• radio interviews
• liaison with other organisations (for example, Schizophrenia Fellowship (now Supporting Families))
• liaison with family members
• involvement in Mental Health Awareness Week.

**SERVICE USER ORGANISATIONS**

Service user-run organisations often adopt a different approach to anti-discrimination, influenced by identity politics in ways similar to the civil rights, gay and women’s movements. These organisations use the politics of identity to situate their work, using terms such as ‘mentalism’ (along the lines of ‘racism’) and ‘coming out’ as having a mental illness. The politics of identity theme fits in well with recovery approaches and shares elements of other anti-discrimination approaches including human rights and disability inclusion.

Collectively, service user organisations, including some regional consumer networks, conduct specific anti-discrimination activities whether funded or not. Anti-discrimination is generally considered too important not to be carried out, and is a defining activity for most service user organisations.

The Wellington Mental Health Consumers Union, for example, has trained local general practitioners in anti-discriminatory practices. The Auckland Regional Consumer Network carries out anti-discriminatory activities without Like Minds funding, as does Centre 401 in Hamilton, which provides services such as:

• a supported employment service to help members gain and keep employment in the open labour market
• support and education for centre members (for example, recovery courses and discharge planning)
• accessing mainstream courses and training for centre members
• advocacy and information
• the training of health providers, students, mental health support workers, social workers etc
• an internalised stigma awareness programme.

In Waikato, the Patients’ Rights Advocacy group lobbies outside of health service provision with over 400 members including law firms, health practitioners and patients’ rights organisations. Its work includes informing service users of their rights and encouraging compliance with laws and codes of practice relevant to service provision.

Most consumer-initiated work focuses on discrimination at the interaction level (that is, face-to-face discrimination), while also dealing with issues relating to internalised stigma. The politics of identity is used by many service user groups to locate themselves and the activities they engage in. The provision of unfunded voluntary discrimination activities raises issues about valuing voluntary services. Specifically, the issue that needs to be addressed is the support that could be offered for service development and possible transition to fully funded providers.

The emergence of national networks of service user groups will make an impact in the future.

**REGIONAL PUBLIC HEALTH UNITS**

Funded through the Ministry of Health’s Public Health Directorate, regional public health units focus on health promotion with a philosophy based on the Ottawa Charter for Health Promotion (WHO 1986). Thus they develop initiatives to mitigate a range of public health issues such as sexual health, smoking, tuberculosis and mental health. As detailed in the earlier section on the Ministry of Health, the public health approach is holistic with initiatives aimed at combating the negative economic, social and cultural factors that influence health status. In relation to mental health promotion, this has led to regional projects that deal directly with anti-discrimination issues.

A number of regional public health units hold Like Minds contracts (and are discussed in Chapter One); but Like Minds contracts do not capture all their anti-discrimination work.

Southern Regional Public Health is typical of many regional public health units. It has three areas of focus in its mental health promotion programme: general mental health promotion, youth suicide prevention (resiliency building) and anti-discrimination against those with mental illness. It is involved with the Like Minds project and produces booklets about mental health stigma and discrimination.

A similar approach is adopted by Crown Public Health, which covers the Canterbury region. Its goal is to
‘promote a social and physical environment which promotes mental health’ by increasing public awareness of mental health issues, reducing suicide, promoting family wellbeing and developing strategies to counter mental illness stigma and discrimination. It does this by networking with mental health services and service users, distributing mental health information, and being involved with the Like Minds project. (See www.cpublichealth.co.nz/About-Us/MentalHealth.asp.)

Regional Public Health, Hutt Valley Health Corporation, for the Wellington area, is perhaps one of the most innovative public health units. It was one of the first Like Minds providers to initiate a Speakers Bureau, which provides opportunities for service users to talk about their experiences of mental illness, discrimination and recovery to audiences, including clinical psychiatric staff – an effective way of combating discrimination, based as it is on contact in a setting where service users are in a prestigious role (as speakers).

Mental health promotion work within regional public health units is heavily guided by Building on Strengths (Ministry of Health 2002a), discussed in Chapter Two. Regional providers contribute much to mental health anti-discrimination work – and could potentially contribute much more – working within overarching national frameworks such as Building on Strengths and having a distinct local input. Training of the public health workforce in anti-discrimination work is an issue that needs addressing, as health promotion training does not necessarily cover this.

To conclude, regional and local providers make a particular contribution to mental health anti-discrimination work, as they provide a distinct local input even though most are working under overarching national frameworks such as national mental health standards or public health agendas. Service user organisations work from recovery and rights perspectives, sometimes with little funding, and could be encouraged with further support. Mental health service providers and public health providers could be encouraged to pay more attention to anti-discrimination work. For service providers, it should be understood that working against stigma and discrimination is an integral part of service delivery, as well as something that occurs in stand-alone programmes or as part of policies designed to meet Standard 18. Delivering mental health services free from stigma and discrimination, and which encourage non-discriminatory attitudes and behaviour in the communities where they are located, is a key to successful services with positive outcomes for service users.
Most mental health anti-discrimination work is conducted by public or NGO sector agencies and organisations, as described in the previous four chapters. However, there are several other significant types of endeavour that make distinctive contributions. In this final chapter of our stocktake we discuss anti-discrimination activities carried out in research, arts and culture and private enterprise.

**RESEARCH**

Research, locally and internationally, has the potential to contribute to anti-discrimination against mental illness by:

- identifying the social and psychological processes involved in stigma and discrimination
- documenting and analysing the ways in which stigma and discrimination operate in society
- researching effective techniques to combat stigma and discrimination.

**Funding sources for research on stigma and discrimination**

Most social and health research in New Zealand is carried out in the university sector. The research culture of universities encourages independent scientific inquiry, and research projects are usually initiated by individuals rather than agencies. Several factors influence the topics that academics choose to research, including:

- the availability of research funding for particular research topics
- the potential for contribution to international scholarship
- local relevance.

Research funding is usually contestable and awarded on the basis of excellence, although funding bodies may set overarching goals and priorities. The Health Research Council is the largest funder of health research, although research on mental health stigma could receive funding elsewhere, for example, from the Foundation for Research, Science and Technology, internal university funds, Lotteries, charitable trusts or even grants from international sources.

The Mental Health Research and Development Strategy, funded by the Ministry of Health and administered by the Health Research Council, is a further source of mental health research funding which has the potential to fund research on stigma and discrimination. It is not contestable; instead it devises projects in line with its own priorities and tenders them out. Its aim is ‘to promote research and development that assists the recovery of people who experience mental illness and/or alcohol and drug problems, and to translate results into mental health policy and practice’ (Mental Health Research and Development Strategy 2003: 1). It locates anti-discrimination research within broad framework of:

understanding the wider system that impacts upon mental health (i.e. the social, cultural, economic and environmental context of mental health – the drivers for and impact of discrimination, the importance of housing, the impact of employment, poverty and the benefit process ...). (www.mhrds.govt.nz)

Mental health sector organisations involved in anti-discrimination activities, such as the Ministry of Health, the Mental Health Commission and mental health providers have some capacity to conduct or contract research on stigma and discrimination. Like Minds also has an active research programme focused largely on evaluation, but extending more broadly on occasion.
New Zealand research into stigma and discrimination

From time to time, studies of New Zealanders’ attitudes towards mental illness have been conducted. The earlier ones were mainly with university students. Walkey, Green and Taylor and colleagues from the Victoria University of Wellington conducted a series of studies that compared attitudes from 1962 to 1994 and found very little change. The prevailing stereotypes remained negative – people with a mental illness are seen as unpredictable, dangerous and tense (Green, Walkey, Taylor & McCormick 1987; Walkey, Green & Taylor, n.d.) In a 20-year follow up to Green and colleagues’ studies, there was some evidence that stereotypes were, in 2003, less negative than reported twenty years previously. At the same time, stereotypes held by members of the broader population were more negative than those reported by students (Wilson & Bryson, 2004).

A community survey, carried out in Dunedin, found evidence of more informed and enlightened views than in earlier times, especially if respondents had known someone with a mental illness (Ng, Martin & Romans 1995). However, social distance scales used as part of the research did reveal more intolerant attitudes, and the researchers concluded that measurement techniques affected findings in this area.

Patten (1992) in research conducted for the Mental Health Policy Section of the Department of Health reported on a national random telephone survey, along with focus groups and key informant interviews “confirmed the widespread belief that the public view mental illness negatively and hold misconceptions about it” (p.vi). The reported suggested that there was a “real potential” for public education programmes aimed at attitude change.

These attitude studies were conducted before the Like Minds project started and cannot be assumed to accurately describe current attitudes; for more recent work, the studies conducted in tandem with Like Minds to benchmark and assess the project’s advertising campaign’s effectiveness should be examined (see Chapter One, references to BRC Marketing and Social Research 2002; Ministry of Health 2001; Wyllie 2002).

Read, from the University of Auckland, along with colleagues and students, has used attitude studies to investigate the utility of medical model anti-discrimination campaigns (Read 2002; Read and Harre 2001; Read and Law 1999; Walker and Read 2002). Their focus is on ‘the extent to which biogenetic causal beliefs maintain fear and stigma’, arising from a concern that medically oriented anti-stigma programmes, internationally, have often tried to convince the public that mental illness is an illness just like any other illness (from www.psych.auckland.ac.nz/psych/staff/JohnRead.htm). Such an approach, they argue, is unsuccessful because their findings indicate that people who believe mental illness is caused by biological factors are more likely to hold stigmatising attitudes than those who believe in psycho-social causes of mental illness. Their research implies that New Zealand’s Like Minds project is on the right track, since it does not focus on mental illness as being like any other illness, but on the people who experience it as being like any other people (the ‘common humanity’ approach).

Forthcoming research on attitudes relevant to discrimination includes the development of a recovery attitudes questionnaire by Boddy and colleagues at Massey University, as well as a public survey of stigma from other Massey researchers who are linked into a cross-national research project originating in the United States.

Attitude studies have been a traditional way of researching stigma and discrimination, but other research approaches have also been used. Nairn and colleagues, from the University of Auckland, have applied discourse analysis to mass media depictions of mental health and illness (Allen and Nairn 1997; Coverdale, Nairn 1997; Nairn 1999; Nairn and Claasen 2000; Nairn, Coverdale and Claasen 2001; Wilson et al 2000; Wilson et al 1999a; Wilson et al 1999b). Their research on television and print media found ‘an overwhelming negativity of depictions of the mentally ill’ (Wilson et al 1999b: 232). A focus of their research programme is on how people engage with media depictions, and the finding is that readers and viewers use the same kinds of commonsense understandings of mental illness to interpret media stories as are used by media to construct stories. This means that even non-sensationalised materials can reaffirm everyday beliefs: in the case of news reports ‘the associations between dangerousness and mental illness are woven into the very fabric of these texts’ (Allen and Nairn 1997: 379).

The Mental Health Commission also examined print media in order to rate how positive or negative portrayals of mental illness were. The results were presented in the publication Discrimination Times (2000), and showed disturbingly negative portrayals;
however, a yet-to-be-published resurvey conducted in 2004 is showing some improvement. In order to provide accurate information as an antidote to media representations, a study on the relationship between mental illness and homicide in New Zealand was commissioned by the Mental Health Research and Development Strategy (Simpson, McKenna, Moskowitz, Skipworth & Barry-Walsh 2003). Their study showed that “mentally abnormal homicides” are rare events, the rates are low and they remain unchanged over the period 1970-2000 and there is no evidence to suggest that services or the public are less safe than they were in more institutionalised times.

Research into the experience of discrimination, as well as into public attitudes and media depictions, is also important. The Mental Health Foundation, contracted to Like Minds, recently completed a major survey of experiences of discrimination (this was described in the Like Minds chapter of this report). There has also been some qualitative research into experiences of stigma and discrimination. Lapsley and colleagues from the University of Waikato, using a narrative approach, found that stigma was the most commonly mentioned barrier to recovery from mental health problems (Lapsley, Nikora and Black 2002) and MacKenzie (2003) examined the ways psychiatric stigma interacts with employment experience. Phoenix Research, contracted to Like Minds, has also conducted some qualitative research as a background to the advertising campaigns. The Mental Health Commission, in a forthcoming qualitative study, will be examining “championing the cause”, focusing on how it is for people of draw on their lived experience of mental illness in order to promote anti-discrimination.

Some research into the effectiveness of anti-discrimination work has been carried out by Phoenix and other evaluators. This was also mentioned in Chapter One.

Altogether, there has been a surprising amount of research on stigma and discrimination in New Zealand, considering that this is such a small country. Given the innovative nature of Like Minds and the strong investment from government in removing discrimination, further research should be encouraged since the landscape of discrimination may well be changing.

ARTS, LITERATURE, FILM AND POPULAR CULTURE

Representations of mental illness in books, films, television and other media are often negative, drawing on inaccurate stereotypes and promoting associations between mental illness and dangerousness. However, arts and cultural activities can also be powerful mechanisms for anti-discrimination. Even though their inspiration lies in a different realm from mental health sector work, artists, writers, poets and filmmakers can convey similar messages, with potentially higher impact, to those arising from more formal anti-discrimination work.

One of New Zealand’s best known writers, Janet Frame, raised public awareness of mental illness and the plight of people in ‘mental institutions’ through her internationally successful 1961 novel, Faces in the Water, and her later works of autobiography (Frame 1982; 1984; 1985), which were made into an award-winning film, An Angel at My Table (Campion 1990). Frame, who had spent years in and out of hospitals during her young adulthood wrote Faces in the Water “to get rid of painful memories – or at least come face to face with them”. Initially she had not intended to publish it, but then decided that it should be published:

‘if a few revelations...would help to get [hospitals] improved and perhaps help change the public attitude to mental illness...Old buildings can be pulled down and new ones put up almost overnight but it is harder to deal with the invisible structures, the medieval castles of suspicion and fear...I do have a sense of responsibility in this matter for – who knows – I might have been still wandering around the yard of Ward Two and being told that there was no hope for me for the rest of my life’ (cited in King, 2000, p.207).

Although Frame herself was a very private person, her work has often been used by campaigners for the rights of people with mental illness, not just in New Zealand but around the world (Szasz 1973).

Autobiographies and memoirs (including self-published works) often present lived experiences of mental illness, and documentary films can put such experiences before a wider audience. Like Minds initiated the television documentaries The Person Next Door and Sticks and Stones, which told personal stories. The short film The Whirling Man tells of the
work of one of New Zealand’s earliest mental health activists, Arnold Brooker (Mornin and Hollings 2000).

New Zealanders’ experience of arts and culture is dominated by overseas products. Popular culture reaches many people and as such, it is a powerful means both of combating discrimination and also entrenched it. Movie portrayals and references to mental illness, including in New Zealand movies, are often discriminatory. But there are exceptions and when the film *A Beautiful Mind* (Howard 2001), a Hollywood ‘biopic’ about mathematician John Nash who was diagnosed with schizophrenia, was released in New Zealand, some local groups took up the opportunity for positive publicity about mental illness.

It is not only popular culture representations that convey and strengthen discriminatory attitudes towards mental illness by drawing on stereotypes. In more artistic and creative works stereotypes still abound. In literature, for example, madness may be used as a device to represent the socially undesirable or hidden aspects of life, as in the ‘madwoman in the attic’ of Victorian novels. Madness and mental health institutions may figure in art as social critique, mental illness being associated with desperation arising from poverty, racism and social rejection or the condition of women (Showalter 1987). Psychiatric institutions, in film and literature, can represent the curtailment of freedom (Charlotte Randall’s *The Curative* 2000) or be powerful statements about the rejection of authority (as in the novel and film, *One Flew Over the Cuckoo’s Nest* (Kesey 1962; Forman 1975). In effect, portrayals using madness as a device to comment on broader social relations may valorise madness, and in that way work against discrimination, but they may also include stereotypical representations of mental illness as subversive of authority, symbolic of social breakdown and the antithesis of rationality.

Giving voice to the experience of illness using museum, library and cultural sector strategies has been a very successful strategy in anti-discrimination work in other countries. Imaginative museum and library projects have included:

- A collection of video interviews from service users who experienced psychiatric institutions in Britain captured in the Mental Health Testimony Archive and released by the British Library in association with Mental Health Media (http://www.mhmedia.com/products/health.html #testimony).

- The Willard Suitcase Exhibition showing the personal stories of patients at the Willard Psychiatric Institute through the contents of their suitcases and was displayed at New York State Museum (www.omh.state.ny.us/omhweb/omhq/q0900/archive.htm).

Unfortunately, little of this type of anti-discrimination work has taken place via New Zealand’s cultural sector.

Within the mental health sector, artistic efforts have been seen as important in anti-discrimination work. The Mental Health Commission’s foundational anti-discrimination document, *A Travel Guide for People on the Journeys towards Equality, Respect and Rights for People who Experience Mental Illness* (1998), suggests using drama, art works, dance, music and other art forms to educate people about mental illness and includes Creative New Zealand and the Arts Access Trust as organisations that should be included as ‘travellers’ on the anti-discrimination journey.

The arts have often been used in mental health as a form of therapy or meaningful activity. Music therapy, art therapy and arts access programmes have a significant history in New Zealand. On their own, they do not constitute anti-discriminatory work, but when the products emerging from studios such as Pablos in Wellington, the Artsenta in Dunedin or Lincoln Green in Christchurch are displayed, they do have an anti-discrimination potential. They reveal high levels of artistic accomplishment in people experiencing mental illness and sometimes deal directly with the mental illness experience and so educate the public. Pablos recently developed a gallery dedicated to promoting ‘outsider art’.

In the NGO sector, Pathways has exhibited work by artists with experience of mental illness and Supporting Families put together a photographic exhibition depicting people with mental illness and their families. The Like Minds project’s regional providers have used the arts to circulate their messages, including videos, CDs, plays, concerts, puppetry and an art installation. The arts sector also adds value to other Like Minds activities, with two musicians featuring in its television advertising campaign, and a high quality of artistic design in its national materials.

Eames (2003) has commented that disability culture, as a social movement, is currently emphasising
identity through art that positively affirms pride and diversity. Mad Pride concerts have been very successful in subverting discriminatory attitudes, and have been held at mental health conferences in New Zealand and Australia, and musical road shows are a regular feature of Mental Health Awareness Day in Auckland.

Doubts about the cost-benefit ratio of artistic productions have led the Like Minds project to discourage one-off types of venture such as drama shows (Ministry of Health 2003b: 24). There has also been criticism of the messages contained in some artistic ventures designed to educate people about mental health, for example, a play about youth suicide recently caused some consternation in the public health sector. Stand-alone service user initiatives have sometimes had difficulty in obtaining funding.

In conclusion, arts and culture has the potential to increase discrimination, but these powerful media also produce anti-discrimination messages that have enormous impact. Harnessing the creative vitality of arts and culture for anti-discrimination work and ensuring positive outcomes that offer value for money is not always easy, but this is a pathway that should never be overlooked.

PRIVATE SECTOR

Commercial interests may also engage in anti-discrimination activity, notably the promotional activities and community liaison work of pharmaceutical companies.

Here we note just two examples which are representative of their efforts.

Eli Lilly has produced information pamphlets about people with serious mental illness and their journey towards recovery. It has also employed a community liaison manager who is developing partnerships with non-governmental organisations and District Health Boards. Part of this role includes running programmes that may serve to destigmatise mental illness. Eli Lilly has also sponsored community mental health conferences and is producing videos about schizophrenia and bipolar disorder.

Janssen-Cilag recently set up a website, mindnz.co.nz, which is an information resource for people with psychosis and for caregivers. Its objectives include challenging stigma through education, and publicity material for the website including a pamphlet on myths about schizophrenia. As well as drug information and factual information on mental illness, the website contains a gallery of art and poetry from service users associated with Toi Ora Live Arts (Making Spaces for Art in Mental Health); as well as a section inviting service users to share their stories.

Drug companies can be expected to use a medical model in their approach to anti-discrimination, with stigma seen as getting in the way of access to and uptake of treatment, and an emphasis on mental illness as brain disease. Their medical language may sit uneasily with other approaches to anti-discrimination and their materials are likely to emphasise the utility of their particular medications, but these particular companies have also provided some useful recovery and anti-stigma information.
Our rationale for conducting a stocktake was that there has been considerable growth in activities addressing the stigma and discrimination associated with mental illness since the Mason Report (1996) recommended that considerable work was needed in this area. The establishment of the Mental Health Commission and the Like Minds project as an outcome of the Mason Inquiry led to major efforts, and in an early piece of work, the Mental Health Commission’s *Travel Guide for People on the Journeys Towards Equality, Respect and Rights for People Who Experience Mental Illness* (1998b) outlined destinations and pathways for work in the field.

After all the developments since the mid-1990s it now makes sense to talk about a sector engaged in mental health anti-discrimination activities. We suggested in the introduction to this document that our stocktake would ask a number of questions about this sector: about roles, responsibilities, and the range and kinds of anti-discrimination activities being undertaken. In these conclusions we attempt to convey briefly what we have learnt from the stocktake by undertaking answers to the questions we posed.

**Who is undertaking the work of mental health anti-discrimination?**

The range of organisations responsible for and involved in anti-discrimination surprised us. Although we thought we knew the sector quite well before we began the stocktake, we did not have such a clear perception of who is doing and who should be doing the work.

Within government we identified four sectors who cover most of the territory: mental health (Ministry of Health Mental Health Directorate, Mental Health Commission), public health (Ministry of Health Public Health Directorate, housing the Like Minds programme) human rights (Ministry of Justice, Human Rights Commission and Office of the Health and Disability Commissioner) and disability (Office of Disability Issues, Ministry of Social Development). However, we noted that all government agencies have obligations to anti-discrimination provisions and programmes, and some agencies contribute in other ways as well. National professional societies and NGOs representing mental health sector interests are also engaged, albeit to various degrees. At regional and local levels, mental health services provided by both District Health Boards and NGOs have their human rights and Mental Health Standard 18 obligations to fulfil and service user groups are also part of the landscape. Finally, research, arts and culture, and commercial sectors all make distinctive contributions to mental health anti-discrimination work in New Zealand.

**What are their roles and obligations?**

Organisations carry out mental health anti-discrimination work for a range of reasons, ranging from legislative obligations to passionate commitment. Overarching legislation such as the Bill of Rights and Human Rights Act place legal obligations on organisations and offers redress for discrimination; health, disability and human rights strategies, plans and standards give direction and shape to the work at national and local levels. The legislation empowering Commissions, and the constitutions and other guiding documents of other organisations, give many organisations a mandate to engage in anti-discrimination work. As well as those organisations with obligations, other individuals and groups freely engage in anti-discrimination work – service user groups, artists and musicians, researchers and even pharmaceutical companies.
What is their approach to anti-discrimination work?

We believe that one of the achievements of this stocktake is to identify and describe the range of philosophies of and approaches to anti-discrimination work. We identified a number of approaches currently being used in New Zealand today: medical model, recovery, whanaungatanga, fonofale, public health, human rights and disability inclusion. We developed our understanding of approaches using the pioneering work of Sayce (2000) and expanded the approaches she had identified to fit what is happening in New Zealand. In the process it became clear that, although beliefs about and understandings of mental illness and discrimination shape anti-discrimination work, it is sector location that most strongly determines the approach that an organisation will take.

We also delineated the processes involved in stigma and discrimination (Appendix 1) and established that different activities target different parts of this process. We noted, too, that different agencies are likely to focus more on stigma or more on discrimination. We discussed the suggestion that anti-discrimination activities should focus less on stigma and more on discrimination and while agreeing with the need to emphasise discrimination, we established that there is still value in focusing on stigma as well.

The implication of this analysis is that there is unlikely to be a unified approach to anti-discrimination work across sectors. However, by understanding the range of approaches and the sectors they live in, organisations should achieve a better understanding of their own work and that of other organisations. This means that they should be able to engage more usefully in networking and collaboration. Also, undertaking the work from a range of perspectives is more likely to achieve success across a wide range of spheres and populations, although there is always the caution that some approaches may not work well or may unintentionally increase discrimination.

It should also be noted that approaches to anti-discrimination are evolving rather than fixed. For instance, disability inclusion is a relatively recent approach for the disability sector. Māori and Pacific work around anti-discrimination tends to use more general health and mental health models for their communities, but models specific to anti-discrimination no doubt will develop as the work proceeds.

What kinds of anti-discrimination activities are they undertaking?

There is a wide range of activities being undertaken, in terms of types of programme and activity and target population. Anti-discrimination activities include legislation, complaints resolution, service standards and monitoring, EEO programmes in workplaces, mass media campaigns, activities engaging with the media, workshops and other learning situations, protests, publications, story-telling, arts and culture activities, research – the list goes on. As well as the formal programmes, anti-discrimination activities occur in a myriad of ways at the informal level through social interactions amongst and between service users/tangata whaiora, service providers, families and whānau, agencies and the general public.

Are they meeting their obligations?

On the whole, national organisations that have obligations (as part of their legislative requirements or mission statements) to involve themselves in this work (e.g. Like Minds, the various commissions and government departments) mostly meet their obligations, at least to some extent. Although not obligated in a statutory way, some professional associations relating to the mental health workforce need to contribute more to public education and to the professional education of their members. National NGOs have a range of goals, but more coordination and support for those groups, especially those with strong service user involvement, should result in increased impact and effectiveness in terms of anti-discrimination.

Across the mental health sector as a whole, and looking at regional and local provision, recent monitoring and reporting obligations mean that services pay attention to their Standard 18 obligations,
but in our view they could do considerably more, including paying attention to stigma and discrimination within their own services as well as their communities. Mental health services have tremendous opportunities, both through everyday work and special programmes, to combat stigma and discrimination, and we would like to see them all involved in this task in a more lively and committed way.

**Is their work making a difference?**

Because such a range of work goes on, at national and local levels, and with different target groups, the question of impact and effectiveness is hard to answer. Overall, we know from national surveys, particularly those conducted for Like Minds, that stigmatising and discriminatory attitudes across the whole population are decreasing. Qualitative research for Like Minds helps keep abreast of changing public understandings of mental illness. All this work suggests that in terms of overall impact, the work of the sector is going well.

The nationwide media campaigns have been carefully evaluated and have been shown to be effective, but the picture is less clear for most other kinds of intervention. Evaluations of regional Like Minds service provision have been conducted, but these mainly focused on describing what is being delivered, rather than evaluating the impact on local populations. Local providers no doubt vary in their effectiveness, and there are suggestions that some lack alignment to national goals and objectives.

It is not uncommon for evaluations to occur in relation to particular interventions (eg, workshops) and these give feedback on one-off or short term programmes and allow their designers to examine what aspects of their programme have been most effective and what did not work so well.

International research on reducing stigma and discrimination also gives some clues as to effectiveness of approaches, eg, research on the contact hypothesis indicates that contact with members of a stigmatised group is effective, as long as an equal relationship, or a relationship of respect is present. This validates, in a general sense, the work being done by service users to present their stories in workshops, media and other settings. However, although the international research can deliver some general principles regarding effectiveness, there is room for much more local research on what works in the New Zealand context, and for particular target audiences.

The pathways delineated in the *Travel Guide* suggest a framework for indicating progress in the sector. This stocktake suggests that a range of activities have been undertaken to help move New Zealand towards the destinations identified in the *Travel Guide* (see introduction), though there is still a long way to go.

Workforce development is a key issue in relation to making a difference, as the anti-discrimination workforce has evolved informally and the indications are that there are considerable training and development needs for it to become a solid, effective workforce.

**Are they working well alongside others in the field?**

An increasing level of cooperation around anti-discrimination work has developed at central government level, with regular meetings between Like Minds, the Mental Health Commission, the Human Rights Commission and the Office of Disability Issues. Some government departments with great potential for combating stigma and discrimination such as in the education and social development sector could be brought into more regular contact with key agencies. There is room for a stronger emphasis on human rights and social inclusion in the work of anti-discrimination.

There is more room for collaboration at the national level with the NGO sector and professional bodies. So far, Like Minds and the Mental Health Commission, the agencies with the strongest mandate for work in this area, have taken the lead. The strengthening of service user input at the national level should be a priority. The current service user input at this level comes mainly from the National Advisory Group attached to Like Minds and from the Mental Health Commission via its service user reference group, some staff and a Commissioner. This input needs to be reconsidered, reviewed and strengthened.

At the local level, coordination varies depending largely on how Like Minds providers interact with their communities. There is room for increased coordination between Like Minds providers and mental health service providers, each responsible for anti-discrimination work in their own ways.
Are there gaps in the sector?

New Zealand currently has the infrastructure within central government to attend effectively to stigma and discrimination, although organisations taking a lead (Mental Health Commission and Like Minds) are not permanent structures.

NGOs and professional bodies make variable contributions and there are some gaps in terms of potential coverage, discussed in Chapter Five of this report.

Regional and local areas of New Zealand are covered by Like Minds and mental health sector provision, and the issue is not so much whether there are “gaps” but whether sufficient attention is paid from the mental health sector to anti-discrimination, and overall, the variable impact of activities undertaken.

Initiatives arising from individuals and groups, such as research, arts and culture activities need to be encouraged and fostered by funding bodies.

Private sector organisations, particularly those subject to some public sector regulation or self-regulation, in fields as diverse as banking, insurance and mass media, could do more to attend to the discriminatory practices that have been identified as occurring in their fields.

In terms of particular population groups and communities of interest, programmes have been developed specifically by and for Māori and Pacific communities, but attention has only recently begun to paid to Asian communities. In terms of age groups, Like Minds targeted young and mid-adult populations, not specifically focusing on older adults. Not very much has been done to think through how particular communities of interest might deal with stigma and discrimination.

FUTURE NEEDS OF THE SECTOR

This report identified a huge amount of activity relating to mental health stigma and discrimination. In order to keep this work going and ensure it is well coordinated and effective, the issue of future leadership and coordination needs to be addressed. As a result of this stocktake, the Mental Health Commission and Like Minds will be facilitating work across key agencies and organisations looking at the future of the sector. Service user leadership in this work will be key, as “nothing about us without us” must be a central principle of anti-discrimination work. It is our intention to produce an Action Plan that will provide some guidance around the structures that are required to ensure that the good work that has been done so far is continued and that New Zealand continues on its journey towards “equality, respect and rights for people who experience mental illness” (Mental Health Commission, Travel Guide, 1998:1).


Office of Mental Health, New York State. no date. Archives Project: OMH inventory complete, agencies work to preserve records and artifacts. Accessed www.omh.state.ny.us/omhweb/omhq/q0900/archive.htm


Components of the processes involved in discrimination and social exclusion

INTRODUCTION
To conceptualise anti-discrimination work effectively, it is important to understand the psychological and social processes involved in discrimination and social exclusion. This appendix breaks down these processes into distinct components.

Work to reduce stigma and discrimination can address any or all of these components at individual, group and/or systemic levels. Understanding the component of stigma or discrimination that is being addressed should enable providers to develop targeted solutions.

CATEGORISING: PERCEPTIONS OF DIFFERENCE

Explanation:
Categorising is the process of grouping people with (or perceived to have) mental illness or distress and seeing them as different from other people. People find it efficient to think in categories because they can quickly produce impressions and expectations about others, who are seen as belonging to a particular social group.

Application:
Some anti-discrimination campaigns emphasise that people with mental illness are essentially the same as everyone else. However, some service users like to emphasise their distinctiveness, as this allows the attribution of positive values to mental illness, as in Mad Pride. A feeling of difference is also at the heart of group identity, so emphasising similarities too strongly may undercut service user movement values.

NEGATIVE STEREOTYPES: DIFFERENCES ARE NEGATIVE

Explanation:
Just because people are grouped together on the basis of some perceived differences, this does not mean they will necessarily be judged negatively. Differences can be neutral, positive or negative. However, in relation to mental illness, negative stereotypes predominate, leading to prejudice towards people seen as mentally ill.

Negative mental illness stereotypes suggest that people with mental illness are dangerous, unpredictable, incompetent and uncomfortable to be around.

Application:
Some anti-discrimination campaigns use an educational approach to try to show that these stereotypes are not real. For example, by presenting statistics on violence and mental illness to correct the danger stereotype. Other strategies involve presenting people with experience of mental illness positively, especially in ways that specifically counter the stereotypes, for example, presenting people as competent – and even famous! – as well as friendly, approachable and respected by their family and friends.
STIGMATISING AND LABELLING: FIXING THE NEGATIVE JUDGMENT ON CERTAIN PEOPLE

Explanation:
Stigma traditionally meant ‘a mark of disgrace’. It was a visible mark on the body and singled out certain people (for example, people with leprosy) for social shunning. Now stigma does not have to be a visible characteristic, but ‘an attribute that is deeply discrediting’, which reduces the bearer ‘from a whole and usual person to a tainted, discounted one’ (Goffman 1963). To put it another way, stigma brands people with mental illness, linking them to the negative stereotypes.

Contact with mental health services and being diagnosed with a mental illness are usually the beginning of being marked out or labelled as belonging to a social group that is judged negatively.

Being stigmatised leads to feelings of social inferiority and a lack of self-esteem that are pervasive and can persist even if a person is not being treated differently or discriminated against.

Application:
Some campaigns emphasise that people with mental illness have a biologically based disorder that is just like any other illness. It is not contagious; nor is it a sign of a bad character or moral weakness. Therefore, people should be compassionate towards people with mental illness and not judge them negatively. Stigma means people avoid seeking help because they do not want to be labelled as mentally ill. This in turn means they are unfairly deprived of access to mental health services.

However, some service users believe it is more useful to critique the labelling process than to argue for sympathy. Also, there is debate about the biological foundations of mental illness. John Read, in his research on stigma, argued that members of the public who believe mental illness to be biologically based are more likely to hold negative stereotypes than people who think it has psychological or social causes (Read 2002). This raises concerns about campaigns based on medical models of mental illness.

Another concern about traditional anti-stigma campaigns is that focusing on stigma keeps the searchlight on the supposed characteristics of people with mental illness, rather than on the people who do the discriminating. In related efforts, it has been more useful to focus on racism and sexism, as forms of discrimination, than on arguments about whether people belonging to groups considered inferior really are inferior. This is the ‘focus on discrimination, not stigma, argument’ (Sayce 2000).

Some useful work, however, can be directed towards alleviating the low self-esteem and negative self-perceptions experienced by stigmatised groups. These harms arising from stigma can interfere with people’s ability to stand up for themselves and to join forces with others sharing the same stigma.

‘MENTALISM’: SOCIAL DISCOURSES THAT JUSTIFY EXCLUDING STIGMATISED PEOPLE

Explanation:
These social discourses are the ways of talking about, writing about and picturing mental illness that encourage people to believe they are justified in excluding or separating people labelled in this way. They include scapegoating or blaming a group for some social ill, such as when people with mental illness are blamed for the rise in violence in society. The user movement has sometimes referred to this set of stigmatising discourses as ‘mentalism’, a phrase that is parallel to sexism or racism.

Mentalism has its roots in the historical practice of segregating people labelled with mental illness ‘out of sight, out of mind’ in large institutions and cut off from where people usually live. In our era of community treatment, these discourses have shifted to some extent, but still have an underlying theme of social exclusion, keeping people with mental illness out of employment, housing and community participation and, at times, segregating them by the force of law from the rest of the community.

Application:
Campaigns focusing on ‘community inclusion’ that work against the exclusion of people who experience mental illness or distress from employment, housing and so on are working against mentalism.

Service user movements have mounted a more direct critique of the practices of the mental health systems that contribute to mentalism, as well as the language and concepts of the medical model.
DISCRIMINATION: ACTIONS INVOLVED IN EXCLUDING PEOPLE

Explanation:
Certain actions or failures to act can lead to the exclusion or loss of status of people with mental illness or distress – this is often called discrimination.

Discrimination is also defined as the treatment of people differently and unfairly because of their membership in a particular social group that is considered inferior.

Application:
Work against discrimination includes campaigns to encourage people with mental illness to assert their legal rights and campaigns to change discriminatory policies and practices among members of the public, organisations and government departments and within the law.

SUMMARY
Understanding the components of discrimination and social exclusion helps us understand more about the problems we are trying to resolve.
INTRODUCTION

Taking Stock incorporates research projects conducted over 2002 to 2004, including the:

- Anti-Discrimination Framework Project, which developed a framework to enhance conceptual understanding of anti-discrimination in the mental health sector (MacKenzie 2002)
- Anti-Discrimination Framework Evaluation Project, which used the Anti-Discrimination Framework to assess the Mental Health Commission’s work programme and develop further conceptual elements of the framework (McCurdy 2003)
- Sector Description Project, which described the anti-discrimination sector in mental health and used the Anti-Discrimination Framework to guide analysis (Bateman 2003)
- Anti-Discrimination Activities: Interviewing the Sector Project, which provided an inside look at the anti-discrimination sector from staff closely involved with it (Public Policy and Research and Centre for Research Evaluation and Social Assessment 2003).

The methods for each project are outlined below and are followed by an explanation of how they were brought together in Taking Stock.

ANTI-DISCRIMINATION FRAMEWORK PROJECT

The Mental Health Commission wanted to develop its theoretical understanding of anti-discrimination activity. Much of the Commission’s earlier work, such as A Travel Guide for People on the Journeys towards Equality, Respect and Rights for People who Experience Mental Illness and its associated Map of Journeys (MHC 1998b), was informed by theory, but was largely descriptive. By outlining the different theoretical perspectives on anti-discrimination activity in the Anti-Discrimination Framework, the Commission hoped to have a tool for planning and evaluating future work.

The researcher adopted a meta-analytic approach where the available theoretical literature on mental health anti-discrimination was interpreted and then classified according to differences in approach. Theoretical ‘types’ were identified by assessing the underlying assumptions of theory and thus the logical remedies to discrimination (for example, the public health promotion approach assumes all elements of society (communities, policy, the environment etc) lead to discrimination, so addressing all these concerns will eliminate discrimination). The framework organises different theories and the components of theory.

ANTI-DISCRIMINATION FRAMEWORK EVALUATION PROJECT

The Anti-Discrimination Framework Evaluation Project involved 90 documents generated by the Mental Health Commission being coded (that is, categorised in a manner commonly used in qualitative data analysis) and analysed using the Anti-Discrimination Framework. The documents included strategic planning papers, submissions to government agencies, media releases and inter-agency correspondence. Notes were kept during the coding process and the degree of ‘fit’ between the framework and the data was assessed. A high degree of ‘fit’ meant the framework fit reality well; a poor degree of ‘fit’ meant the framework needed to be altered.
SECTOR DESCRIPTION PROJECT

Documents were collected from a range of organisations involved, directly and indirectly, with the mental health sector. Initial interviews were conducted with a small number of experts in the field to assess the range of documents required and from whom. Many documents were available from the Mental Health Commission’s library, while others were obtained from interviewees. Many policy and strategic documents were obtained from the internet.

The documents were used to overview the roles and responsibilities of key organisations. The Anti-Discrimination Framework was also used to code and analyse each agency’s approach, scope and strategies.

ANTI-DISCRIMINATION ACTIVITIES: INTERVIEWING THE SECTOR PROJECT

This project was an interview study. The object of the interviews was to gain the views of key people involved in anti-discrimination work or critical to people’s recovery.

Interview participants were selected from people working in:

- mental health service user-run anti-discrimination programmes
- District Health Board (DHB) public health providers
- community-based services for people with mental illness
- government agencies with generic responsibilities for anti-discrimination work
- key professional and clinical positions in the mental health sector
- agencies in other sectors in which discrimination may have significant negative outcomes for people experiencing or having experienced mental illness.

Those interviewed were selected after an initial consultation with the Commission, and then ‘snowballing’ to include others suggested by interviewees. After the first interviews in Wellington, it became clear it would be important to include organisations based regionally or locally to understand the perspectives and experiences of organisations working in mental health on the ground. Consequently, selected organisations were included from the Waikato and Bay of Plenty.

Due to time constraints on the project, it was not possible to formally conduct an interview with any DHB mental health provider.

Sixteen people participated in the interviews (see Appendix C).

INTEGRATING THE DATA

The four reports that contributed to Taking Stock allow a triangulated view of the anti-discrimination activity in mental health. Starting with the purely theoretical approach that led to the Anti-Discrimination Framework, followed by document analyses and finally indepth interviewing, we were able to get a reasonably accurate picture of the shape, size and direction of the anti-discrimination sector. Drafts of this report were also sent to key stakeholders to gain their comments.
Interviewees for ‘Anti-Discrimination Activity’

People from the following organisations were interviewed for Anti-Discrimination Activity: Key Interviews (Public Policy and Research and the Centre for Research Evaluation and Social Assessment 2003):

- Centre 401 (Hamilton)
- College of Psychiatrists (a committee member)
- Group Special Education, Ministry of Education
- Human Rights Commission
- Mental Health Commission
- Mental Health Foundation
- National Advisory Group for Like Minds
- New Progress Enterprises (Hamilton)
- Office of Disability Issues
- Pathways (Hamilton)
- Public Health Directorate, Ministry of Health
- Regional Public Health (Wellington Region)
- Schizophrenia Fellowship
- Serious Fun ‘N’ Mind (Bay of Plenty)

Deborah Wells, Consumer Consultant, and Dr John Read were also interviewed.