‘People seeking wellness’*
Mental health information in New Zealand and Australia

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* English translation of the Maori term ‘tangata whaiora’, which many New Zealanders who use mental health services have adopted to describe themselves

Contents

Executive summary

Background and scope
This research concerns the various approaches taken to providing public information about mental health issues in Australia and New Zealand.

Forty-five individuals in the two countries were interviewed, including academics, people from voluntary sector organisations, state health providers, and government ministries.

The research was conducted between October and December 2001.

Structure of research
The interviews were informal ones of about an hour, with questions covering four main areas:

Who are the audiences for your communications?
How do you decide what you tell them?
What media do you use for dissemination, and why?
Does it work?

This report is divided along the same lines, with main sections on audiences, knowledge base, choosing and using the medium, and evaluation. Each section also contains a case study.

Findings

Audiences
The main audiences for the communications studied were users/consumers of mental health services, families and/or carers, mental health professionals, and the wider public. Different organisations took quite different approaches to their audiences, with some seeing them as needing education, some seeing them as resources to provide content and assist dissemination, and some seeing them as partners.

- Case study

Like Minds Like Mine: The project to Counter Stigma and Discrimination Associated with Mental Illness (Campaign by the New Zealand Ministry of Health)

Key factors:
- ✓ a public health approach
- ✓ involvement of people with mental health problems
- ✓ buy-in from the mental health sector
- ✓ using the mass media to influence attitudes
- ✓ the importance of community action
- ✓ a rights based approach
- ✓ stakeholder buy-in
- ✓ consistency with national health policies.

- Key messages from research concerning audiences

1. Define your audiences carefully and comprehensively. They may not be who you think, and they may change over time.
2. Ask your audiences what information they need, rather than assuming you know.
3. Pilot content and design with a cross-section of your audience, and be prepared to take on board their assessments.
4. See audiences as active participants rather then passive recipients.
5. Encourage audience feedback, either structured (via questionnaires) or unstructured.
6. But beware of consultation fatigue!

Knowledge base

The nature of mental health problems and the best ways to deal with it have been the subject of argument between researchers, people with mental health problems, families and carers, professionals and policy-makers for decades. All mental health organisations must therefore decide what ‘the facts’ about mental health are.

Some organisations I visited focused on refuting what they saw an ‘misinformation’ about mental health problems, for example theories of the family causation of schizophrenia. Others, mainly those working at mental health promotion, focused on population wide causes of mental health problems – poverty, discrimination and lack of social connectedness. Others focused on the concept of evidence-based medicine – making sure that assessments of the effectiveness of treatments are backed up by medical trials.

- Case study

Help for depression: What Works and What Doesn’t (Book by Centre for Mental Health Research, Australian National University)

Key factors:

- ✓ Treatments grouped into three sections: medical treatments, psychological treatments and lifestyle/alternative treatments, which reflect different understandings of mental ill-health.
- ✓ Text designed for reading level of grade 8.
- ✓ Systematic reviews of scientific literature carried out using electronic databases PubMed, PsycLit and the Cochrane Library.
- ✓ Researchers reviewed clinical practice guidelines, popular web sites, Amazon.com’s top 25 books on stress management, treatments mentioned in leaflets from pharmacies and health food shops, review articles on complementary therapies.

  - ✓ Treatments assessed cover an extremely range from traditional medical to alternative.
  - ✓ Key sources of evidence for each of the treatment assessments are given.

- Key messages from research concerning knowledge base

  1. Always be explicit about your own position with regards to causes and treatments of mental ill-health.
  2. Cite complete references for all information presented as fact.
  3. Be clear about sponsors and any commercial interests involved in a project.
  4. Translate information about population trends into meaningful messages for individuals
  5. Present all options for treatments, and the pros and cons of each.
  6. Respect differing understandings and opinions about the causes and treatments of mental health problems, and represent a range wherever possible.
  7. Make provision for the review of information as the evidence base evolves.

Choosing and using the medium

The organisations consulted for this study used a very wide variety of media to disseminate their messages, from publishing traditional printed reports to organising training meetings to advertising in the mass media.

The main messages were caution about using the mass media - which is a reinforcer rather than an opinion former –and a focus on facilitating word of mouth and face-to-face dissemination. This was particularly true in New Zealand, with a relatively small population and also considerable Maori influence, which values face to face/kanohi ki te kanohi communication a great deal.

The lack of use of the internet was surprising, the only real exception being the Centre for Mental Health Research at Australian National University, which has focused a lot of its work on this medium.

- Case study

Depression Awareness/Recognition Programme (Community education project by the Mental Health Research Institute, Melbourne)

Key factors
  - ✓ Community development approach to create ‘community educators’ on the subject of depression
  - ✓ Reference group of mental health professionals, trainers, relatives and carers
  - ✓ Evaluation of the training material

  - ✓ Partnership with local mental health organisations to access their networks at grassroots to recruit volunteers for training
  - ✓ Support for the volunteer trainers in their attempts to disseminate information within their local communities

- Key messages from research concerning choosing and using the medium

  1. Select the correct medium for your audience, and ask them their preferences. Be flexible about medium you use, and be prepared to present the same information in more than one medium.
  2. Make the most of synergy across media – promote the web on printed publications, and vice versa, for example.
  3. Decide if the information you are providing is a service or a revenue generator. Be explicit about this, structure prices accordingly and consistently.
  4. Use each medium to its best potential: interactivity on the web, depth of understanding and ease of assimilation in print, public events for immediate impact with targeted groups, mass media for simple messages.
  5. Don't forget about word of mouth as the most effective medium of all.

Evaluation

A number of the organisations consulted have mechanisms in place to solicit feedback from their audiences, in more or less formal ways. Web sites in particular have become a recognised channel for asking audiences their views on information they are given, whether on the site itself or in other publications produced by the organisation. Some organisations had more effective mechanisms of ensuring that feedback had an active impact on future plans.

The larger public health campaigns conducted telephone surveys of public opinion, while recognising them as relatively crude instruments of measurement. There was a tendency for the smaller organisations to overlook evaluation and assessment, partly because it is seen as too expensive.

- Case study

MoodGYM: Assessment of use (Web site based on cognitive behavioural therapy for people with mild to moderate depression)

Key factors:

  - ✓ Site usage measures included number of sessions, hits, average time on the server and number of page views
  - ✓ Results showed over 17,000 separate sessions in the first six months of the site

- ✓ Visitor characteristics included gender and initial ratings on the Goldberg scale (a measure for anxiety and depression)
- ✓ Symptom changes were measured on Goldberg scores on five separate occasions
- ✓ Users who completed at least one self-assessment had above average anxiety and depression measures
- ✓ Both anxiety and depression scores decreased significantly as users progressed through the modules.

Key messages from research concerning evaluation

1. If possible, formal evaluation should be costed in as part of each communications project or strategy.
2. As a minimum, audience feedback should be encouraged, whether in writing, via a web site, or by phone.
3. Structured questions as to how relevant, accessible and effective audiences find information are preferable to asking solely for open-ended comment.
4. Ensure that mechanisms exist to acknowledge individuals who give feedback.
5. Make provision for analysing and acting on evaluation results, either in revisions of existing material, or in planning new projects.

Acknowledgements

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1. Aims and background

This research concerns the various approaches taken to providing public information about a broad range of mental health issues in Australia and New Zealand.

Public mental health campaigns in both New Zealand and Australia in the mid to late 1990s attracted international attention. As a UK publishing and communications consultant with experience in the mental health field, I was interested to discover more about these, and other initiatives undertaken in both countries since.

Populations and land areas of New Zealand and Australia

	Population	Land area (km^2)
New Zealand	3.7 million	270,000
Australia	19 million	7.5 million
(United Kingdom	60 million	250,000)

Health care in New Zealand

New Zealand health care has traditionally been provided by the state and funded directly by tax-payers. In the 1980s, mental health services New Zealand in underwent the same process of de-institutionalisation as in many other countries.

In 1991, major reforms to the structure of NZ public health care based on the principles of ‘user pays’, internal competition, greater cost efficiency and a reduced role for the state were introduced. A Public Health Commission was given responsibility for health protection, health promotion and disease prevention. Four Regional Health Authorities were charged with purchasing health services from a mixture of public and private providers, with a focus on efficiency objectives.

The 1991 reforms received a mixed reaction from those in the field of mental health. Many had been dissatisfied with the mental health services previously provided, and saw the reforms as a chance to introduce flexibility and innovation, for example allowing non-government organisations (NGOs) with an interest in mental health services far greater scope. They also increased the influence of public health approaches to mental health care. However, there were worries about a reduction in public accountability, and increasingly inconsistent services across different regions in the country.

Another round of reforms currently being introduced has seen a retrenchment towards a more ‘mixed economy’ of care. Regional Health Authorities have been replaced by 21 District Health Boards - based around previous hospital administration regions - who are now responsible for purchasing health services, including mental health services, according to the needs of their local population.

Health care in Australia

A universal system of health insurance, Medicare, was introduced in Australia in 1984. It is funded, in part, through a hypothecated tax on income of 1.5 per cent. Medicare’s two main functions are to cover the cost of services by medical practitioners and of public hospital care.

Australia has a strongly federal structure, with state governments having a great deal of political and administrative power – including, for example, providing public hospital services.

Under Medicare, Australians are entitled to free public hospital care when choosing to be public patients. Doctors who are appointed by the hospitals provide their medical treatment.

Medicare also meets the bulk of costs for all out-of-hospital medical services, such as general practitioner and specialist consultations. The Medicare contribution is 85 per cent of standard fees, which are set by the federal government for each type of service. Many doctors charge more than the standard fee and the patient pays the difference.

About one-third of all Australians take out private health insurance. This covers treatment as a private patient in both public and private hospitals. In the private sector, patients can choose to pay directly for medical costs or use private health insurance.

Private hospitals provide about a quarter of all hospital beds in Australia. Private medical practitioners provide most non-bed medical services and perform a large proportion of hospital services alongside salaried doctors.

Federal government policy is to encourage more people to take out private health insurance, while preserving Medicare as the ‘safety net’.

Just as in many other countries, mental health services have made the move to community care in the last two decades. Generally, those with less severe mental health problems are treated in the private sector, while public mental health services care for those diagnosed with more severe illnesses.

Scope of this research

Forty-five organisations and individuals were consulted over seven weeks between October and December 2001. In Australia the majority of interviews were in Melbourne and Canberra; in New Zealand the majority were in Auckland and Wellington. Most consultations took the form of individual interviews, usually of about an hour. Two were conducted by phone and follow-up e.mail. The interviews were broad-ranging and informal, and focused on publishing – mainly print but also the internet – as well as media and PR work.

Questions were grouped into four main areas:

Who is the audience for your communications?
How do you decide what you tell them?
What media do you use for dissemination and why?
Does it work?

I have divided the main content of this report along roughly the same lines:

audiences
knowledge base
choice of medium/dissemination
evaluation

In each of these sections I have included case studies to highlight a particular aspect of the research. Each organisation and individual I consulted made an invaluable contribution to this research, either in the particular or in my general understanding of mental health and communications issues in Australia and New Zealand. I am very grateful to everyone for making the research such an enjoyable and useful experience.

A note on terminology

Language is a very vexed issue in mental health.

Except where quoting directly, I have used the terms ‘users of mental health services’ and ‘people with mental health problems’ (generally accepted terms in the UK) and ‘consumers’ (generally accepted term in Australia and New Zealand) interchangeably.

The term ‘carer’ is generally used in the UK and Australia. In New Zealand, the term ‘family/whanau’ is preferred (‘whanau’ is Maori for family and is understood to include not just blood relations but all those who are close to a person).

2. Results

2.1 Audiences

The main audiences for the communications studied here were:

users/consumer of health services
their families and/or carers
mental health professionals
the wider public

Consulting your audience

The organisations consulted had varying approaches to their audiences. SANE Australia, a ‘national charity helping people seriously affected by mental illness’, sees its role as one of education:

> ‘We tend to talk most about educating the general public about mental health issues, but there is also an important role for organisations such as ours in educating consumers and carers too.’
> *Barbara Hocking, SANE Australia*

Other organisations saw their audiences as a resource. Huia Communications, who administer Like Minds Like Mine, New Zealand’s national ‘campaign to reduce stigma and discrimination associated with mental illness’ (see case study 1), commented:

> ‘Research shows the most effective communications about mental health issues are from people who have experienced mental health problems. We have incorporated the expertise of consumers, as well as carers and service providers, in all our communications work.’
> *Theresa Pomeroy, Huia Communications*

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is currently producing clinical guidelines for practitioners, and companion guides for consumers and carers, on five key topics/diagnoses: anorexia nervosa, bipolar disorder, deliberate self-harm, major depression, panic and agoraphobia, schizophrenia. A comprehensive plan for consultation with each of these stakeholders groups is attempting to ensure the maximum ‘buy-in’ from all parties:

> ‘A sizable literature exists on the problem of poor quality guidelines….in the areas of validity, reliability and credibility. Research shows the need for guidelines to be scrutinised by both expert assessors for scientific validity, as well as by end users – consumers and practitioners.’ *Jonine Penrose-Wall, RANZCP*

Appraisal tools such as Discern, an instrument for assessing the quality of health information for consumers, have been employed to allow stakeholders to give structured and constructive feedback. A good deal of attention is being paid to getting genuine feedback:

> ‘Formal links with existing consumer group are essential in order to widen consultation, but participants in our bi-national [Australia and NZ] workshop for consumers and carers were told that they were not being asked to rubber stamp the series. Rather, they were encouraged to be critical and detailed in their scrutiny of the drafts.’ *Jonine Penrose-Wall, RANZCP*

Similarly, the Mental Health Commission of New Zealand regarded audience or stakeholder consultation as the key to good communications:

> ‘Good communications for us are about effective and relevant stakeholder consultation and strong relationship management. To that end we work closely with service users, funders and service providers – all the key stakeholders – in both creating and disseminating our messages.’ *Barbara Disley, Mental Health Commission*

The Mental Health Commission also warned, however, of consultation fatigue:

> ‘It’s important that communication is two-way, but we need to beware of asking the same people the same questions over and over.’ *Barbara Disley, Mental Health Commission*

For their survey on consumer and family opinion about mental health services, the Commission collated information from a number of existing pieces of research, rather than going back to consumers and carers asking them to repeat themselves - a potentially demoralising experience for everyone.

Audiences with specific needs

Consultation with audiences could lead to customising communications to very local needs. The Carers Association of Victoria (the Australian state of which Melbourne is the capital) encourages regional workers to identify the information gaps in local psychiatric disability services:

> ‘Every area mental health service has its own budget to address the information gaps. One region used the money to fund a loose-leaf kit for carers on medical information – “what is this diagnosis”, “what are the treatments” and so on. Another region did very brief introductory leaflets on mental health services, as a lot of their clients did not have English as a first language. Another region has used the money to start up a web site to provide up-to-date service information with a carer angle.’ *Julie Nankervis, Carers Association of Victoria*

VicHealth, the statutory health promotion agency of the state of Victoria, is undertaking a major mental health promotion campaign. They were faced with the need to split their potentially huge public audience:

> ‘Opportunities for prevention and promotion in the mental health field exist across a range of population groups. With finite resources and in accordance with VicHealth’s Strategic plan, mental health promotion activities are focused on the following groups: Kooris [the main Aboriginal group in Victoria], young people, older women and men, people in rural communities, people newly arrived in Australia.’
> *VicHealth, Mental Health Promotion Plan 1999-2002*

VicHealth tested their campaign materials with focus groups from each of these sections of the community. VicHealth have eschewed costly media advertising in the first stages of their campaign, preferring instead to focus on grassroots promotion with community groups within the target audiences.

Changes in audience profiles

Several interviewees commented on the need to be flexible in defining your audience, not to make assumptions, and to be alive to changes in service or policy that may affect the composition of your audiences. David Clarke of VicServ, ‘the peak body for psychiatric disability support services in Victoria’, commented that the key audience for their communications at the moment is general practitioners:

> ‘We might assume that other health professionals would know what we do, and what psychiatric disability support services are. But since changes in mental health services in Victoria to make them more primary care focused, we are being inundated with inappropriate referrals from GPs. So a great deal of our communications effort at the moment is re-orientated to telling GPs what VicServ does.’ *David Clarke, VicServ*

Megan McQueenie of the Mental Health Foundation of Australia (Victoria), ‘an organisation of professionals, sufferers, families of sufferers, and related organisations concerned with mental health’ described how in the early days of mental health campaigns in Australia they realised that they were merely:

> ‘preaching to the converted. We had very patchy promotion activities – we would organise things like visits to the local ECT suite in hospitals. We had very limited success. We were simply not reaching the ordinary general public. Now, since the National Mental Health Strategy in Australia, we have national funding for mental health awareness week, a focus on mental health rather than mental illness, and activities concentrate much more on “fun events” for the general public.’ *Megan McQueenie, Mental Health Foundation of Australia*

The New Zealand Like Minds Like Mine campaign (see case study 1), initially focused on the discrimination that users of mental health services experienced at the hands of the general public. As the campaign has progressed, they have shifted attention to discrimination within mental health services themselves:

> ‘We realised we needed to include mental health workers more in the campaign. Research in New Zealand has shown that people working in mental health services may devalue their clients. And workers themselves are undervalued and marginalized. So it is really important that workers are a targeted by the campaign, and have the opportunity to contribute to it.’ *Damiane Rikihana, Huia Communications*

Case Study 1

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

Public health campaign funded by the New Zealand Ministry of Health

Background

The project was established in response to the 1996 Mason Report, an influential inquiry into the state of NZ mental health services:

> '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 realise that [people with a mental illness] are people whom we should nurture and value.'
> *Mason Report, NZ Ministry of Health 1996*

Aims of the campaign

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

- empowering individual people with experience of mental illness to gain equality, respect and rights
- putting mental health on people's personal agendas
- educating people about what mental illness is
- promoting greater understanding of people with mental illness
- changing public and private sector policy to reflect the above
- communicating the above effectively with all key groups in New Zealand, including people with experience of mental illness, statutory agencies, GPs, health agencies, other governmental agencies such as Housing New Zealand, and people with other disabilities. *National Plan 2001-2003*

Key factors

- A public health approach

'A public health paradigm has been key to the success of the campaign.' *Janice Wilson, Ministry of Health*

The campaign draws heavily on the concepts put forward in the WHO's *Ottawa Charter for Health Promotion*, namely building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orienting health services.

- Involvement of people with mental health problems

Research has shown that the best way to combat negative attitudes mental illness is to promote contact between the public and people who have experienced mental health problems. Their involvement is seen as critical in the success of the project, as is supporting them while they undertake education and training work for the project.

- Buy-in from the mental health sector

Recognising both that discrimination against consumers occurs within mental health services, and that mental health workers themselves feel devalued and marginalized.

- Using the mass media to influence attitudes

The media plays a crucial role in perpetuating people's attitudes, but is slow to change them. LMLM has used the mass media – including TV and national print media – judiciously. A documentary featuring well-known New Zealanders talking about their experience of mental health problems was particularly well received, but was held back until the campaign had been bedded down with key stakeholders.

- The importance of community action

To build on awareness created in the mass media. Grassroots initiatives – education and training at local community level – allow the LMLM message to be adapted to local conditions and differing cultures.

- A rights based approach

Highlighting the rights of people with mental health problems as citizens, rather than soliciting pity for them as sufferers.

- Stakeholder buy-in

At the start of the campaign, the Ministry of Health conducted a national mass media campaign, and regional health authorities conducted local community activities. There was no shared vision, and relationships among stakeholders were poor. In 1998 a national co-ordinator was appointed, a single body took over all funding and regional plans were amalgamated into one national plan. The eventual launch of the national mass media campaign in 2000 gave the project a strongly unified national profile while leaving room for regional and culturally different initiatives.

- Consistency with national health policies

The LMLM campaigns aims are consistent with national policy in mental health, public health, Maori mental health and Pacific health.

References

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

Key messages

7. Define your audiences carefully and comprehensively. They may not be who you think, and they may change over time.
8. Ask your audiences what information they need, rather than assuming you know.
9. Pilot content and design with a cross-section of your audience, and be prepared to take on board their assessments.
10. See audiences as active participants rather then passive recipients.
11. Encourage audience feedback, either structured (via questionnaires) or unstructured.
12. But beware of consultation fatigue!

2.2 Knowledge base

The nature of mental health problems and the best ways to deal with it have been the subject of argument between researchers, people with mental health problems, families and carers, professionals and policy-makers for decades.

In addition, the concept of evidence-based medicine – determining treatments according to proven outcome measures - has become an important principle in health care in many countries in recent years, including New Zealand and Australia.

Given these factors, how did different organisations decide what 'the facts' about mental health problems, causes and treatments were?

Causes of mental health problems

Some organisations are concerned with refuting what they see as dangerous theories about the cause of mental ill-health:

> 'The idea of family causation in schizophrenia has done a terrible amount of harm. We must get across the message that schizophrenia is a treatable illness, like any other illness. And families do not cause it – no matter how badly you treat someone you are not going to give them schizophrenia.' *Barbara Hocking, SANE Australia*

SANE emphasise this view on individual causation in all their literature. By contrast, VicHealth, the health promotion agency for the Australian state of Victoria, looked at the knowledge base for what determines the mental health of whole communities. They use a broad definition of mental health, which is more than the absence of mental illness:

> 'Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just'. *VicHealth, Mental Health Promotion Plan 1999-2002*

VicHealth identified social connectedness, economic participation and freedom from discrimination as the three key determinants of mental health:

> 'An individual's level of social integration and social support are powerful predictors of their mental health status, morbidity and mortality.
>
> The link between employment and health status is now emerging as a key concern… [Australian research shows] unemployed people

> experience higher levels of depression, anxiety and distress as well as lower self-esteem and confidence.
>
> The link between discrimination and mental ill health is clear, with discrimination resulting in lower self-esteem, social isolation, depression, anxiety, drug and alcohol use and suicidal feelings. For example [Australian research shows] that the indigenous youth suicide rate [i.e. for Aboriginal peoples] is four times the non-indigenous rate.' *VicHealth, Mental Health Promotion Plan*

The difficulty for mental health promotion is making research about mental health determinants across whole populations meaningful in an individual context. 'Your mental health will be better if you have a job' is not necessarily a helpful message – indeed arguably could be an unhelpful one. Maree Davidson, consultant to VicHealth, acknowledged this problem:

> 'There are certainly anxieties as to how to approach this campaign. If we say that isolation leads to poorer mental health, will that make people think "I feel isolated, so that means I will go mad." VicHealth was certainly nervous about that possibility. It is one of the reasons we decided not to go with a big media campaign.' *Maree Davidson, VicHealth*

When VicHealth first launched their campaign materials containing messages such as 'getting hostile puts the body under stress' and 'intolerance can increase the risk of serious illness', they found that people telephoned the office wanting to talk about their experiences of bullying or other intolerance or hostility - even though there was no explicit 'call to action', and the VicHealth number was not printed on the campaign material. VicHealth itself had no way of responding to these calls initially. They have addressed this by providing a web site to back up the campaign that signposts people to organisations that can help with particular problems.

Treatments for mental health problems

Tony Jorm of the Centre for Mental Health Research at the Australian National University in Canberra has developed the concept of mental health literacy:

> ‘Mental health literacy is about the public’s ability to recognise mental health problems, where they can get help, and what treatments are available. It is very important that we get quality information directly to consumers. It’s not enough just to give it to professionals. That kind of top-down approach does not really work.’
> *Tony Jorm, Centre for Mental Health Research*

In the mid-1990s, Jorm asked 2000 members of the Australian public about their views of depression and schizophrenia and their treatment. He then asked the same questions of mental health professionals – psychiatrists, clinical psychologists, mental health nurses and GPs.

Jorm found a gulf between the public’s perception of treatments and the professionals’. The public had much more positive views of what Jorm terms ‘lifestyle’ treatments – such as dietary change, exercise, social contact – and a negative view of the effectiveness of medical interventions. Professionals had a negative view of lifestyle treatments and a positive view of medical treatments.

Marge Jackson, project worker at KITES, a mental health NGO in Wellington, New Zealand commented that the concept of evidence-based treatment was not as straightforward as some might think:

> ‘You will hear many consumers talking about alternative treatments. Often others will ask “did it work – are you better?” The answer is quite often “well no, but the process of doing it made me feel better anyway”. I think it’s quite an important point when we are thinking about “evidence”, and “outcomes” – what criteria are we using to judge these?’ *Marge Jackson, KITES*

Acknowledging the spectrum of views and approaches to treatments is, in Tony Jorm’s view, central to providing good mental health information:

> ‘We group our information around three themes: lifestyle, medical and psychological. You have to present information that accords with individuals’ own views about the most effective treatments for mental health problems. Otherwise the information will simply not be effective, it won’t have any impact on people’s health-seeking behaviour.’ *Tony Jorm, Centre for Mental Health Research*

In New Zealand, the Mental Health Foundation is the principal provider of information about mental ill-health. Their web site, which receives over 100,000 hits a month, offers information on diagnoses or conditions in a series called MHINZ – Mental Health Information New Zealand:

> ‘MHINZ was part of a larger government funded initiative in 1997 to improve the quality of information for people with mental health problems and their families/carers. MHINZ has proved very successful and highlighted a clear gap in information provision in New Zealand.’
> *Jade Furness, Mental Health Foundation of New Zealand*

The Foundation explicitly acknowledges differences of opinion about causes and treatment – particularly between consumers and family/whanau – and outlines differing views to allow readers to make their own interpretations.

The Depression Awareness Recognition Project (DARP) from the Melbourne Mental Health Research Institute uses what they call a ‘bio-psycho-social model’ of depression:

> ‘All the interventions described under DARP will be evidence-based. We are not solely coming from a medical model, but recognise that science does not (yet) have all the answers about the causes and treatments of depression, but that what works for one person may not work for another. Therefore we aim to present accurate information and emphasise the importance of getting an evaluation early, and looking at all the possible factors. In a sense we are beginning at the beginning – providing information to let people know that depression is relevant in their community and can be treated.’
> *Kylee Bellingham, Mental Health Research Institute*

The Royal Australian and New Zealand (RANZCP) clinical guidelines project sees its main purpose as improving health outcomes for patients by improving the practice of clinicians. They are focused on clinical evidence, but consumer and carer appraisals have also distilled two key philosophies:

> ‘There was a consensus from all participants in the consumer/carer appraisal workshop that the clinical guidelines provide encouragement in treatment (hope) and that they emphasise a treatment relationship and enhance communication that is three-way – between the practitioner, consumer and carer’ *Jonine Penrose-Wall, RANZCP*

Case study 2

Help for Depression: What Works and What Doesn’t

Book produced by the Centre for Mental Health Research, Australian National University, Canberra

Background

Tony Jorm and his team at the Centre for Mental Health Research have conducted a large body of research into public knowledge and attitudes towards mental health problems.

In the mid 1990s Jorm and colleagues coined the term ‘mental health literacy’ to describe people’s ability to recognise problems, knowledge about where to seek help, and knowledge of treatment options. They have also conducted research into the quality of information about depression available to the general public, (focusing in particular on the internet in recent years). They found the overall quality of information to be poor – incomplete, inaccessible, unreliable, out of date or not properly sourced.

Jorm and colleagues believe that health-seeking behaviour is best influenced by getting accurate health information to consumers, not just professionals. They also believe that people will seek treatments that accord with their beliefs about the causes of mental ill-health, and that presenting evidence about the efficacy of a broad range of treatments is the most effective way to promote informed choice.

Aims of the book

The book is intended to enable people who have never been in contact with mental health services to gain access to the same quality of information that professionals would expect in order to be able to make judgements about the efficacy of various treatments for depression.

Key factors

- Treatments reviewed are grouped into three sections: medical treatments, psychological treatments and lifestyle/alternative treatments. Research evidence on each one is presented in the same way.
- The text is designed to have a reading level of grade 8.
- Systematic reviews of scientific literature were carried out using electronic databases PubMed, PsycLit and the Cochrane Library. The results of all randomised controlled trials on a particular treatment were evaluated. Where no randomised controlled trials were found, the results of observational studies were used.
- In order to decided which treatments were evaluated, the researchers reviewed clinical practice guidelines for depression, 21 popular web sites on depression, Amazon.com’s top 25 books on stress management, treatments mentioned in leaflets from

pharmacies and health food shops, review articles on complementary therapies for mental disorders

- Treatments assessed cover an extremely broad range from traditional medical to alternative, including: antidepressants, ECT, tranquillisers, transcranial magnetic stimulation, oestrogen, cognitive behaviour therapy, hypnotherapy, interpersonal psychotherapy, bibliotherapy (self-help books), psychodynamic psychotherapy, supportive counselling, St John's wort, exercise, light therapy, acupuncture, alcohol avoidance, aromatherapy, caffeine avoidance, chocolate, colour therapy, dance and movement therapy, exercise, fish oils, ginkgo biloba, ginseng, homoeopathy, lemon balm, meditation, music, natural progesterone, painkillers, pets, sugar avoidance, vervain, vitamins, massage therapy, negative air ionisation, relaxation therapy, vitamins, yoga
- The key sources of evidence for each of the treatment assessments are given.

References

Jorm, A., Christensen, H., Griffiths, K., Korten, A., and Rodgers, B. (2001) *Help for Depression: What Works and What Doesn't* Canberra: Centre for Mental Health Research, Australian National University

Key messages

8. Always be explicit about your own position with regards to causes and treatments of mental ill-health.
9. Cite complete references for all information presented as fact.
10. Be clear about sponsors and any commercial interests involved in a project.
11. Translate information about population trends into meaningful messages for individuals
12. Present all options for treatments, and the pros and cons and each.
13. Respect differing understandings and opinions about the causes and treatments of mental health problems, and represent a range wherever possible.
14. Make provision for the review of information as the evidence base evolves.

2.3 Choosing and using the medium

The organisations consulted for this study used a very wide variety of media to disseminate their messages, from publishing traditional printed reports to creating web sites, organising training meetings to advertising in the mass media.

Printed material
Printed resources are generally still the best way to convey in-depth information to audiences. Print has the advantage of allowing people to take in information at their own pace and keep the material for reference. However, over-reliance on print as a information medium can exclude people whose first language is not English, people who are unable - for example due to a disability - to read printed material, or people who are not used to assimilating information from printed sources.

All the organisations consulted used printed materials. The most popular formats were one-page flyers (usually A4 folded), small format booklets (usually A5), A4 magazines and A4 reports.

Generally, only the flyers would be distributed unsolicited to target audiences. They would contain information about how to obtain more in-depth printed resources for those who wished to follow up. Charging models for publications varied:

> ‘We try to keep all our printed material free, or at very low cost. We are trying to get information out there, and charging for it is a disincentive for many carers.’ *Julie Nankervis, Carers Association of Victoria*
>
> ‘We charge for a number of our publications –we are reliant on this for income, and there is a definite market for what we produce.’ *Paul Morgan, SANE Australia*
>
> ‘We charge for cost recovery only. We need to do this in order to keep up the level of information we do, but we don’t see it as income generating.’ *Jade Furness, Mental Health Foundation of New Zealand*

The web
Despite the increasing important of web sites in integrated communications strategies, very few of the organisations consulted here had put many resources into developing their web sites.

Tony Jorm’s team at the Australian National University were an exception to this trend, having developed two web sites dedicated to information about depression. Their focus on the web came in part from an interest in it as a tool for raising consumer awarness about mental health, and also because it is a highly appropriate tool for reaching young Australian men who, like young men in many industrialised countries, have increasing rates of both depression and suicide.

‘Blue pages’ is in some ways a companion to Jorm and colleagues’ book *Depression: What Works and What Doesn’t* (see case study 2).The researchers had found a very poor level of information about depression on the internet, and created ‘Blue pages’ in part to rectify that. The web site presents meticulous information about treatments for depression, using similar approaches to their book: the division into medical, psychological and ‘lifestyle’ treatments, review of a very broad range of interventions, clear writing style, and citing key sources of evidence:

> ‘The web is such a potentially important tool in improving mental health literacy. We need meticulous, quality information up there. Consumers deserve the same level of quality as professionals when it comes to mental health problems and their treatments.’ *Tony Jorm, Centre for Mental Health Research*

The team’s second web site, ‘MoodGYM’, is intended as a tool for prevention and early intervention in mild to moderate depression. It uses cognitive behavioural therapy (CBT) models as its basis, is aimed at young adults, and leads users through a series of highly structured interactive paths to try and help identify and shift negative thought patterns. CBT has some of the strongest evidence for efficacy in less severe depression, and is the basis of a number of self-help books. The transition to the web is a logical one, and the efficacy of web-based treatments will be studied with much interest as evidence starts to accumulate.

SANE Australia’s StigmaWatch has used the unique qualities of the internet to create a media watchdog. SANE itself monitors the media, principally newspapers and TV, for incidences of stigmatising treatment of mental health issues, and it also encourages web site users to make their own reports. This enables instant and wide-ranging action on media representations, and ‘stigma alerts’ on the site have received media attention themselves.

The project has recently received funding to create a national e.mail network of stigma watchers, and to expand the ‘good news’ section, which details positive and accurate reports or portrayals of mental health problems.

Public events

Published information, whether electronic or printed, is only one part of an effective information strategy. Many of the organisations consulted make extensive use of public events –including training events, conferences and workshops. Huia Communications, which has special expertise in Maori communications, has made particularly effective use of face-to-face[*] communications to spread its message:

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[*] *kanohi ki te kanohi* in Maori.

> ‘It’s about keeping people, informed, involved and feeling that they have a stake in the campaign. We have advisory committees that meet to discuss progress and strategy, and as the project managers we stay in direct personal touch with all the providers who have signed up to the project. There is quite a diversity of groups, who do not always have the same priorities, and we see one of our most important roles as making sure everyone feels included and listened to. There is really no substitute for hui [meetings/face-to-face consultations] for making that happen.’ *Damiane Rikihana, Huia Communications*

The New Zealand Mental Health Commission also puts great importance on personal contact with its stakeholders:

> ‘We visit each of the 26 District Health Boards every year. It’s not an “inspection”. The aim is to make sure we know what the real issues for providers are on the ground. We also have regular hui with tangata whaiora[*] [consumers], with Maori, with Pacific islanders, with carers.’ *Mary O’Hagan, Mental Health Commission of New Zealand*

This approach gives the organisations concerned a reputation for communicating with people rather than at them. It requires commitment and resources to effect on an ongoing basis, but increases the support for, and hence the efficacy of, other information services.

An interesting model of community communication is being piloted by the Depression Awareness Recognition Project (see case study 3) based at the Mental Health Research Institute in Melbourne:

> ‘While we acknowledge the value of education campaigns, our proposal fits more within the rubric of community development. Our model incorporates the use of local communities to develop their own awareness of mood disorders and in particular depression. We plan to make contact with communities through key individuals, with the aim of instilling clear and accurate concepts of depression and how it can be tackled.’ *Neil Cole, Mental Health Research Institute*

Mass media

Most of the organisations visited were very wary about mass media campaigns – mainly because of their high cost and the difficulty of effecting changes in public opinion. However, there were a number of creative ways in which the national media were used to communicate particular messages about mental health.

First of these was intervention in the news media when a particular story was in the headlines. Most organisations had experience of this. As in the

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[*] A Maori term adopted by many in the NZ consumer movement, meaning ‘people seeking wellness’

UK, there have been ‘incidents’ in both Australia and New Zealand where an individual who has had contact with psychiatric services has committed a violent act. The public response has generally been to demand more secure psychiatric facilities and for mental health services to take responsibility for preventing such incidents. The organisations I met with expressed some weariness with constant attempts to battle against these perceptions. Research shows that people with mental health problems are no more likely than anyone else to commit a violent act, but simply repeating this fact seems to do little to shift public opinion. As David Clarke put it:

> ‘Just saying don’t be afraid is not much use, is it. I mean we are told as children not to be afraid and it doesn’t assuage our fears.’ *David Clark, VicServ*

One way to address this impasse has been to intervene not in the news media, but via popular drama. SANE Australia advised the makers of soap opera *Home and Away* on their portrayal of a character called Joey who is diagnosed with schizophrenia. Psychiatrists helped SANE with their advice, and the scriptwriters had access to SANE’s information resources. The plot and characterisation supported SANE’s message that schizophrenia is a treatable illness from which people can recover.

Similarly, when the Australian movie *Shine*, concerning a pianist with mental health problems, was released, there was much debate in the media about mental health problems; SANE used the opportunity to promote its message through op ed pages, letters and radio and TV news interviews.

Evidence tends to show that the media reinforce and perpetuate existing views, rather than making people change their minds. Major public information/education campaigns in mental health have therefore steered clear of costly ‘paid advertising’ – at least until the campaign is well rolled out in key constituencies. According to VicHealth:

> ‘To be effective, strategies designed to influence community understanding and ultimately behaviour, need to work across several different levels: community, structural and environmental. Change is initiated by immediate personal experience, experience of someone whose opinion is valued, structural changes [legal or other regulations], environmental influences [what the community perceives to be acceptable], outside influences such as the opinions of credible sources in the media.’ *Melissa Corkum, Trish Cotter, VicHealth*

VicHealth has therefore divided its campaign into three stages: first the community capacity building, then a mass media campaign, and finally evaluation of outcomes.

Case study 3

Depression Awareness/Recognition Programme (DARP)

Community education project by the Mental Health Research Institute in Melbourne

Background

An Australian survey estimated that 4.2 per cent of men and 7.4 per cent of women had had a depressive disorder in the past 12 months. Only 40 per cent of them had consulted a general practitioner, and very small percentages received help from specialist mental health professionals.

The Depression Awareness/Recognition Project (DARP), which is in its initial stages, will use a community development model to deliver information about the nature of depression and its treatments to the community at large, with a view to encouraging more people to seek medical treatment and to seek it earlier.

Aims of the programme

- Increased recognition of depression and increased access to professional advice and, where necessary, treatment
- The establishment of local networks of resource people and possibly self-help and/or support groups, in urban regional and rural settings
- A reduction in the level of stigma associated with depression over the longer term, within communities
- Development, production and evaluation of the training package that might be used on a national basis

Key factors

- A community development approach will conduct training of selected persons in the use and application of the depression awareness/recognition package, including people from city, town and rural communities, and enable them to be community educators on the subject of depression
- A reference group of mental health professionals, trainers, relatives and carers to ensure that the training material is appropriate
- Evaluation of the training material as it is developed
- Partnership with local mental health organisations to access their networks at grassroots to recruit volunteers for training
- Two-day training courses to include presentations from a psychiatrist, a clinical psychologist and a consumer and carer

- Support for the volunteer trainers in their attempts to disseminate information within their local communities

References

Neil Cole, Wayne Chamley, Tom Trainer, David Copolov *The Development of a Training Approach to Enhance the Levels of Awareness and Understanding of Depression in the Community* Mental Health Research Institute, Melbourne 2001

Key messages

1. Select the correct medium for your audience, and ask them their preferences. Be flexible about medium you use, and be prepared to present the same information in more than one medium.
2. Make the most of synergy across media – promote the web on printed publications, and vice versa, for example.
3. Decide if the information you are providing is a service or a revenue generator. Be explicit about this, structure prices accordingly and consistently.
4. Use each medium to its best potential: interactivity on the web, depth of understanding and ease of assimilation in print, public events for immediate impact with targeted groups, mass media for simple messages.
5. Don’t forget about word of mouth as the most effective medium of all.

2.4 Evaluation

User/audience feedback

There has been a tendency within mental health communications to assume that once the message is ‘out there’, the job is done. This is beginning to change, as organisations recognise the importance of evaluating campaigns and projects in order to plan effectively for the future.

A number of the organisations consulted have mechanisms in place to solicit feedback from their audiences, in more or less formal ways. Web sites in particular have become a recognised channel for asking audiences their views on information they are given, whether on the site itself or in other publications produced by the organisation.

However, once feedback is collected from audiences, it is necessary to have processes that make use of it to influence future communications.

Formal evaluation

In a couple of instances more formal evaluations have been factored in at the start of a project.

One of the advantages of web sites over print is that detailed information about how they are used can be collected as visitors make their way through the site content. In addition, questionnaires can solicit detailed qualitative feedback. When properly analysed the information gained can be used to improve the site on an ongoing basis.

The web sites published by the Centre for Mental Health Research take advantage of these qualities, and the researchers have instigated detailed studies to evaluate the effectiveness of their sites. All visitors to the MoodGYM site over a six-month period were investigated, including nearly 3000 registrants of whom 1500 had completed at least one online mood assessment. The results (see case study 4) were encouraging, showing depressive symptoms decreasing amongst users.

In a public awareness initiative such as New Zealand’s Like Minds Like Mine (LMLM) campaign, effectiveness can only be measured by sampling public opinions before, during after the campaign. As part of this 5-year campaign, a series of TV adverts have been run. The first series of adverts was screened in 2000, and featured a number of prominent New Zealanders discussing their experience of mental health problems:

> ‘The first survey was prior to the first series of advertisements that we ran in 2000. The survey's purpose was to set some benchmark measures around what we thought were some existing public attitudes towards people with mental illness. We then did a tracking survey after the ads had run. We are currently [Jan 2002] doing a third tracking survey, as our new ads will be running in February

> 2002. We will also be doing a fourth tracking survey later in the year to see where public attitude is at as a result of the second ad.'
> *Gerard Vaughan, Ministry of Health*

In the benchmark survey, over 1400 individuals, including 470 Maori, were questioned by telephone. Seventy-six per cent of those surveyed were able to recall at least one mental illness: 63 per cent mentioned schizophrenia, and 28 per cent mentioned depression. Only 15 per cent were aware that one in five New Zealanders experience mental health problems – most thought the figure was one in twenty or one in fifty. People were generally of the opinion that mental health illness could happen to anyone, that people do not always remain unwell, and can make a contribution to society. They also felt they were becoming more accepting of people with mental illness, but were divided as to whether people with mental illness were more dangerous than others.

The tracking survey, conducted in January 2001 after the first series of TV advertisements put out by the campaign, showed some shifts. Over 1200 individuals were questioned by telephone. Schizophrenia was less frequently mentioned (55 per cent) and depression more frequently mentioned (37 per cent). More people (29 per cent compared to 15 per cent) were able to state correctly that one in five New Zealanders experienced mental health problems. Umprompted recall for the ads produced by the campaign was 53 per cent, and the most common messages received from them were that mental illness could happen to anyone and does not constitute a barrier in life. The adverts were felt to raise awareness in a positive way.

Information from the impact of the first series of ads has been crucial in designing the second series, to ensure maximum impact and continuity. The second series of ads, screened in March 2002, featured well-known New Zealanders talking frankly about their experience of mental health problems. They end with a voiceover: 'Like one in five New Zealanders, John Kirwan [All Black rugby player] was affected by mental illness. If you know someone affected, remember: how much they suffer depends on you.'

Case study 4

MoodGYM: Assessment of use

Web site based on cognitive behavioural therapy for people with mild to moderate depression (http://moodgym.anu.edu.au)

Background

Cognitive behavioural therapy (CBT) is well recognised as an effective treatment and prevention for depression when delivered face to face, via self-help books or by computer. MoodGYM is a free internet-based CBT intervention designed to treat and prevent depression in young people.

Aims

- The assessment study documented the site usage, visitor characteristics and changes in depression and anxiety symptoms among users of the site.

Key factors/results

- All visitors to the MoodGYM site over a six month period were investigated, including 2910 registrants of whom 1503 had completed at least one online assessment
- Site usage measures included number of sessions, hits, average time on the server and number of page views
- Visitor characteristics included gender and initial ratings on the Goldberg scale (a measure for anxiety and depression)
- Symptom changes were measured on Goldberg scores on five separate occasions
- Results showed over 17,000 separate sessions in the first six months of the site
- 20 per cent of sessions lasted longer than 16 minutes
- Users who completed at least one self-assessment had above average anxiety and depression measures
- Both anxiety and depression scores decreased significantly as users progressed through the modules.

Reference: Christensen, H. personal correspondence

Key messages

6. If possible, formal evaluation should be costed in as part of each communications project or strategy.
7. As a minimum, audience feedback should be encouraged, whether in writing, via a web site, or by phone.
8. Structured questions as to how relevant, accessible and effective audiences find information are preferable to asking for open-ended comment.
9. Ensure that mechanisms exist to acknowledge individuals who give feedback.
10. Make provision for analysing and acting on evaluation results, either in revisions of existing material, or in planning new projects.

3. Appendix

3.1 Organisations and individuals consulted

(chronological order)

Australia

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