

GLOBAL MADNESS:
A Journey of Policy Influence, Fundraising and Social Inclusion in
New Zealand, USA, Canada and the UK



A Report by
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2007 Churchill Fellow

To study fundraising for
mental health advocacy in
New Zealand, USA, Canada
and the UK

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INDEX

SECTION		PAGE
1	EXECUTIVE SUMMARY	3
2	Introduction and Acknowledgements	4
3	Programme: Itinerary and Organisations	5
4	Main Body and Findings	
	4.1 Social Inclusion	6
	4.2 Policy Influence	14
	4.3 Fundraising	25
5	Conclusions	27
6	Recommendations	29

1. EXECUTIVE SUMMARY

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A SOCIAL INCLUSION CAMPAIGN ON MENTAL HEALTH IN AUSTRALIA

Discrimination against people with psychiatric diagnoses is recognized as a priority issue in all English-speaking OECD countries. Half of us will experience significant mental distress during our lives. Madness is a fully human experience. National social inclusion campaigns on mental health exist in Scotland, England, New Zealand, USA and Canada. Reducing discrimination promotes everybody's mental health, increases economic prosperity, encourages people to seek support, and promotes recovery. In Australia health consumers have identified discrimination as the single largest barrier to recovery.

These campaigns produce results. In Scotland the *See Me* campaign spent £2.3M over four years and halved the percentage of Scots who believe people with mental health problems are dangerous (34% to 17%). *Like Minds* in New Zealand spends NZ\$5M pa and similarly reduced negative attitudes towards people experiencing mental illness.

These campaigns provide Government a return on investment and increase productivity. Research by the Institute of Psychiatry and the London School of Economics finds that an investment in *See Me* of £0.55 per adult person can produce a cost-saving of £4.51 per person: an 800% return on investment. This is because less discrimination increases employment and education opportunities, and increases the likelihood of people seeking support and/or treatment earlier. The earlier people seek support and/or treatment, the less will be spent on health, social and hospital services in the long term.

We know how to implement social inclusion campaigns and we know they work. They are relatively inexpensive and provide a return on investment. Most importantly, they create significant reductions in the pain and suffering people experience as a result of discrimination. We now need such a campaign in Australia. The Queensland Alliance will partner with all those interested in achieving this goal.

AN INTERNATIONAL CENTRE FOR MENTAL HEALTH SYSTEMS REFORM

Community organizations worldwide are working to reform their mental health systems. Many of the leaders I met and spoke with had only limited understanding of policy influence and reform work occurring in other nations. There is limited evidence base or evaluation practice on what works best to reform mental health systems. The skills, approaches, frameworks and strategies of change agents across these nations are not being shared, improved or documented. An international centre for mental health systems reform will operate as a clearinghouse for these activists' skills and knowledge, and accelerate the pace of all our reform efforts.

2. INTRODUCTION AND ACKNOWLEDGEMENTS

My Fellowship¹ was entitled Fundraising for Mental Health Advocacy, which comprised three parts:

1. Social Inclusion/Anti-discrimination social marketing campaigns that change the way people understand mental illness and raise awareness of mental health;
2. Strategies to influence key decision-makers to promote recovery-oriented, community-based responses to mental health needs;
3. Fundraising – how organisations find the funds (especially from non-government sources) to resource the two forms of advocacy described above.

I would like to thank the Churchill Fellowship and the Queensland selection panel for supporting this project and providing me with the opportunity of a lifetime to find out how other countries try to improve mental health systems. I am also extremely grateful that the State Council of the Queensland Alliance approved and supported my absence from the workplace to undertake this Fellowship. It was an extremely busy time for the organization and the strong support of my Board is very much appreciated. I hope my enrichment in turn assists the organization and all our members.

Enormous thanks goes to *all* those people I met who gave of their time and shared their experiences so generously: I am forever in your debt. In particular I must thank the following people for their significant support: Paul Farmer, CEO of Mind, Neasa Martin, consultant to the Mental Health Commission of Canada, Chad Costello, Director of Public Policy at Mental Health America of Los Angeles, and Lauren Spiro, Executive Director at the National Coalition of Mental Health Consumer/Survivor Organisations.

I must express my great appreciation to Professor John Mendoza and my Churchill Fellow Margaret Ward who provided my references to the Trust, and also Professor Margaret Steinberg for her generous time and advice. Professor Myles McGregor-Lowndes and Wendy Scaife from Queensland University of Technology's Centre for Philanthropy and Nonprofit Studies, and Professor Rob Donovan from Curtin University of Technology's Business School, also provided great leads and support during my initial investigation.

Ms Odette Best – 2005 Churchill Fellow on Indigenous Primary Health Care - provided me with personal encouragement and the belief that I could do it. Finally and most importantly I thank my boyfriend, Mr Rod Goodbun, for his ongoing support over nearly twenty years, and especially his support, wisdom and many sacrifices through the entire process of applying for, and undertaking, a Churchill Fellowship.

¹ This work is based on my interviews with more than 100 people and my experiences in thirty-five organizations in four nations. A literature review has not been completed.

3. PROGRAMME: ITINERARY & INTERVIEWEES

14 April	Wellington, New Zealand	Case Consulting Platform Inc
15 – 18 April	Auckland, New Zealand	Mental Health Foundation of NZ Ministry of Health
18 – 25 April	Los Angeles, USA Sacramento, USA Bakersfield, USA	Mental Health America of Greater Los Angeles California Mental Health Directors Association California Network of Mental Health Clients California Council of Community Mental Health Agencies Department of Mental Health, State of California California School Health Centers Project Return Peer Support Network Oversight and Accountability Commission
2 May	Vancouver, Canada	Canadian Mental Health Association – BC Division
5 – 16 May	Washington DC, USA Philadelphia, USA	Mental Health America Pan-American Health Organisation SAMHSA (Substance Abuse and Mental Health Services Agency) – US Department of Health and Human Services The National Coalition of Mental Health Consumer/Survivor Organisations Mental Health Liaison Group Constellar Group Mental Health Association of South-East Pennsylvania
22 – 30 May	Toronto, Canada	Mental Health Commission of Canada Canadian Mental Health Association – Ontario Division Mood Disorders Association of Ontario Mood Disorders Society of Canada Centre for Addiction and Mental Health (CAMH) National Network for Mental Health Sound Times Support Services
2 – 20 June	London, UK Birmingham, UK Uxbridge, UK	Mind NCVO - National Council of Voluntary Organisations <i>Moving People</i> Open Up and Mental Health Media <i>See Me</i> (Scotland) Mental Health Providers Forum Department of Health Institute of Psychiatry, Kings College London

4. MAIN BODY: FINDINGS

Rather than provide the story of my Fellowship, I present here an integrated summary of what I learned from speaking with more than 100 people working in thirty-five organizations in New Zealand, UK, USA and Canada. The material is organized under the three topic areas of my Fellowship.

This section is mainly descriptive with some analysis, leading into the conclusion section where I analyse these findings and then make some recommendations.

4.1 SOCIAL INCLUSION CAMPAIGNS

There is an enormous amount of work occurring in this area globally. There is incredible diversity in the resources and quality of this work both within and between countries. In all four nations there is a blurring of social inclusion (or anti-discrimination or anti-stigma) work with general mental health promotion work. Perhaps social inclusion work is best understood as being one part of a mental health promotion spectrum. Some people argue that social inclusion campaigns are based on a citizenship or human rights model, rather than a health care or social welfare model, and should be seen as distinctly separate from mental health promotion.

In organizations where social model of mental health is strong (eg Mind in UK or Mental Health Foundation of New Zealand) there is a clearer understanding of the difference between general mental health promotion and anti-discrimination work. In Canada and the United States where a medical understanding of mental health dominates, there is much mental health promotion work which is described as social inclusion and/or as having anti-stigma effect. However this work does not really focus on changing attitudes or challenging stereotypes. This situation is reflected in Australia.

In this author's view, social marketing which raises awareness of mental illness, provides information on how to maintain mental health or encourages people to seek treatment, is mental health promotion work. Social inclusion work identifies issues of discrimination against people with a mental illness, challenges negative perceptions and stereotypes, promotes concepts like equality, participation and citizenship, and shows the general public how to include people in families and communities.

4.1.1 New Zealand

Like Minds, Like Mine (www.likeminds.org.nz) is by far the best anti-discrimination campaign and also the longest running (11 years). The campaign is managed by the Ministry of Health with a budget of nearly NZ\$5M p.a. This budget is split in two parts with approximately \$2M allocated to 26 regional providers of community education and anti-discrimination support, most of these consumer-run agencies. Approximately \$2.85M is allocated for the national media campaign, conferences and research.

By the conclusion of my trip it was clear that the *Like Minds* campaign was by far the world's best practice. Recent initiatives in Scotland, Canada and England have learnt significantly from the New Zealand experience and acknowledge *Like Minds* as providing them with leadership and a solid evidence base. The key factors that set *Like Minds* apart are:

- The quality and reach of the TV and radio advertisements is very high;
- The images of people with mental illness are completely positive and normal – while difficult periods are referred to, all the images of people with mental illness are overwhelmingly positive;
- The social marketing message has evolved over time but maintained its focus on addressing discrimination and prejudice rather than encouraging people to seek help (more health promotion approach than social inclusion);
- The leadership of people with a lived experience is significant and there is a very high participation of consumer leaders in the program;
- All TV advertisements feature “real” people with experience of mental illness – there are no actors – and there is diversity in the people selected in terms of age, ethnicity, gender, sexuality, etc.
- Half the overall budget is allocated to 26 grassroots community organizations to undertake “on the ground” activities in local areas and/or with specific populations (Maori, Pacific Islander, Chinese, youth) but under the same banner as the TV advertisements. This “direct contact” generates attitudinal change as discussed below;
- National training is available to support organizations and individuals to undertake social inclusion work in their local communities;
- Research was established from the beginning and the evidence base is significant and demonstrates improvements in attitudes towards people with mental illness;
- Research evidence and the perspectives of people with a lived experience have informed development of the program, and have not always concurred;
- Regular gatherings of all projects occurs on a national level, developing a sense of connection and a national movement with which many identify;
- The public respond positively to the campaign and political representatives have continued to support and enhance expenditure on the campaign – it is ‘perceived’ as a success in New Zealand, and has recently become a permanent, ongoing programme.

And *Like Minds* actually works. The campaign invested significantly in research and evaluation and undertook eight data collections of New Zealanders attitudes towards mental illness. Highlights from these annual surveys show that:

- 51% of New Zealanders would feel ashamed of a mental illness diagnosis in 2006, compared with 65% in first year;
- 25% of New Zealanders would accept a person with mental illness as babysitter to their child, compared to 12% in first year.
- 38% disagree with the statement that people with mental illness are more likely to be dangerous, compared to 27% in first year.

Data following the most recent (phase four) campaign is yet to be published.

While the programme has massive support, a small number of people I met in New Zealand voiced criticisms, which include:

- Some of the local providers' activity tends towards mental health promotion (eg messages like: know the signs and symptoms, if you're not well seek medical treatment). As described above, while these activities are not necessarily negative, they are more health promotion than social inclusion oriented;
- The health focus – rather than a human rights focus – has restricted the extent to which more radical approaches can be deployed, and there needs to be more mobilization of people to protest unfair treatment;
- The local providers are not consistent and not all of them have polished presentation methods which may damage the quality of the “brand”. From other perspectives this diversity is a strength and appropriate to the needs of diverse audiences;
- Social marketing overload – there have been too many campaigns on a range of social issues and people are starting to switch off from the message.

Despite these concerns, every person I met with spoke very positively of *Like Minds*, and all people with lived experience described how positive and energized they felt seeing “people like me” on the TV saying that we should be treated equal.

One significant piece of research looked at the range of ways discrimination can be addressed, to identify the most effective approach. This research (http://caseconsulting.co.nz/images/stories/pdfs/power_of_contact.pdf) found that direct contact with people with mental illness is THE most effective means of shifting people's attitudes, providing this contact occurs in a situation where:

- there is equal status
- The opportunity for individuals to get to know each other
- Information provided challenges negative stereotypes
- Active co-operation
- Pursuit of a mutual goal.

This finding is reinforced in USA, Canada and UK where there is a proliferation of speakers' bureaus and range of other mechanisms to give voice to people with mental illness and support them to “tell their story” directly and publicly. While a literature review has not been undertaken recent articles from Corrigan in USA, and very recently Thornicroft confirm direct contact and social marketing as most effective means challenge negative attitudes.

4.1.2 United States of America

SAMHSA (Substance Abuse and Mental Health Services Administration) of the US Department of Health and Human Services has a considerable array of anti-stigma and anti-discrimination (now called social inclusion) initiatives, many of which have been evaluated and researched. These campaigns, however, have more limited resources per capita than *Like Minds* and their reach is therefore significantly reduced. Additionally, the diverse nature and messages of these campaigns means there is a more limited national profile.

SAMHSA's main resource center is called ADS: originally standing for Address Discrimination and Stigma associated with mental illness, now changed to Acceptance, Dignity and Social Inclusion for Mental Health. As in New Zealand "stigma" is perceived as a stigmatizing word which makes discrimination on the basis of mental health somehow different or set apart from other forms of prejudice. The ADS Center has a full listing of all social inclusion initiatives across the USA which can be searched by topic, audience or geographical area (www.stopstigma.samhsa.gov).

The Center for Mental Health Services within SAMHSA also produces a range of resources, tool kits and action guides on challenging discrimination and developing anti-stigma campaigns. The most recent campaign from SAMHSA can be found at www.whatadifference.samhsa.gov.

Community organizations in America, however, have also been established to undertake this type of work (eg No kidding? Me too! www.nkm2.com) or undertake social inclusion within a mental health promotion context (eg Half of Us www.halfofus.com) or are existing mental health service providers or advocacy agencies that challenge discrimination and stigma along with a full range of other services and activities (eg www.mentalhealthamerica.net).

The National Mental Health Awareness Campaign (www.nostigma.org) is a good example of how anti-discrimination and health promotion messages are attempted simultaneously. It has a two-pronged goal: encourage people to identify, discuss, and seek help for mental health problems; and create a more accepting environment for them to do so. There is considerable literature which suggests information that promotes a biological basis to mental illness reinforces stigma. For this reason I believe the inclusion of help seeking messages detracts from the anti-discrimination message.

4.1.3 Canada

Once again there is a very large number of initiatives in Canada. They are very localized, often small production budgets and mental health week activities remain the only nationally coordinated examples. The newly formed Canadian Mental Health Commission has a mandate to address discrimination, and has collated a national listing of activities and projects nationally. The Commission has a request for tender document

out for the development of a national social marketing campaign to address discrimination.

Neasa Martin – a consultant to the MHCC on anti-discrimination strategy – has undertaken extensive consultation and research on this campaign. Her report (http://www.mentalhealthcommission.ca/documents/TimeforAction_Eng.pdf) sets out findings from this consultation, and includes appendices which list anti-discrimination programs across Canada, as well as programs in Australia, New Zealand, USA and UK. The conclusions of this report are similar to that from other countries and include the importance of consumer leadership in campaign development and the power of Direct Contact.

There is again a range of approaches and mix of health promotion with social inclusion in Canada. The Mood Disorders Association of Ontario (MDAO) has produced some innovative health promotion material with a component that challenges stigma (eg film competitions, awards nights, gala dinners, and www.checkupfromtheneckup.ca). The Executive Director of MDAO, Karen Liberman, is a person with direct experience of mental illness who has done an enormous amount of public speaking and awareness raising (<http://www.mooddorders.on.ca/message.html>). Ms Liberman is a charismatic leader supported by a team of paid and volunteer professionals with significant experience in marketing and advertising. However MDAO resources are focused on encouraging people to seek treatment rather than challenging discrimination or stigma.

The Mood Disorders Society of Canada (MDSC) is led by Phil Upshall, another charismatic leader with direct experience of mental illness. The MDSC has produced a small rubber elephant to represent stigma: the Elephant in the room. This is a lobbying technique used to highlight that discrimination and stigma against people with mental illness is so often the elephant in the room: the issue which impacts on all aspects of mental health but is never spoken about. MDSC are heavily involved in the Faces of Mental Illness campaign for Mental Health Week (<http://www.miaaw.ca/en/campaign/overview.aspx>) and strongly support the Mental Health Commission of Canada and its anti-stigma commitments.

Many initiatives take the form of speakers' bureaus and promotion – mainly through print media as there are insufficient resources to undertake TV advertising – of individuals who are prepared to “come out” as having a mental illness. These initiatives again reinforce the importance of first person narratives and the attitude changing impact of direct contact. Examples include the Faces of Mental Illness (above) or the Transforming Lives posters of people and their stories from the Centre for Addiction and Mental Health (<http://www.camh.net>).

4.1.4 United Kingdom

Scotland's *See Me* Campaign (www.seemescotland.org.uk) has been going for four years and attempts to replicate in Scotland a similar model to *Like Minds*, in that there is centralized “national” branding and then a series of local activities. Unlike *Like Minds*,

however, *See Me* is a non-government entity, comprised of a coalition of five pre-existing mental health NGOs: Scottish Association of Mental Health, Highland Users Group, Penumbra, National Schizophrenia Fellowship Scotland, and Royal College of Psychiatrists – Scottish Division. Over four years *See Me* has received £2.3M. The next three year plan has just been completed.

See Me was able to look at the experience of New Zealand, the World Psychiatric Association's "Open the Doors" campaign and England's "Mind Out for Mental Health" campaign. In their four-year review *See Me* states: "Taking time to look at the evidence of what works led us to devise a campaign which integrated high profile publicity with ongoing local activity. It was also clear that personal testimony by those with first-hand experience of stigma is a powerful tool in any campaign to tackle prejudice."

The *See Me* review by the Scottish Executive after four years of activity achieved the following changes:

- 17% of Scots believe people with mental health problems are dangerous, compared to 34% pre-campaign;
- 52% young people disagree that people with mental health problems are less likely to have friends, compared to 35% pre-campaign.

A smaller scale campaign undertaken by Rethink in Norwich, England also achieved significant changes: 30% of people were prepared to disclose mental illness (only 15% beforehand), 21% thought people were dangerous (33% beforehand), and 22% would not tell anyone of a mental health problem (40% beforehand).

This is just a sample of prior activity in anti-discrimination work in the UK. This evidence was used by three English mental health charities: mind (www.mind.org.uk), rethink (www.rethink.org) and mental health media (<http://www.mhmedia.com/>) to come together and seek funding for a new social inclusion initiative for England and Wales. The Institute of Psychiatry, Kings College London is undertaking the evaluation of the initiative.

The Institute of Psychiatry, Kings College London with the London School of Economics has undertaken a study of the economic implications of stigma and discrimination against people with mental illness. They identify that our existing negative attitudes towards people with mental illness include the following negative consequences:

- Longer periods of untreated mental illness (DUP = duration of untreated psychosis) because stigma acts as a barrier for those who need treatment. Psychiatric research identifies that the longer a person with mental illness waits to seek treatment – ie the longer the DUP - the more negative the outcomes for the person and the more expensive and longer term the ultimate intervention will be;
- Disincentive to invest in mental health over other areas of health as mental health investment is not perceived as popular;
- Discrimination for those trying to stay in employment and also those attempting to gain employment;

- Discrimination for children in the school system (either due to their own illness or parents' illness) and the impact of less favourable treatment on their learning and long term opportunities.

People with mental illness would also identify significant personal costs in friends, workmates and families, as well as the costs of social exclusion in terms of access to support networks and other generally available community services. This research did not include these factors.

An economic model was developed by the IOP looking at both depression and schizophrenia. In the schizophrenia model they did not include any changes in employment outcomes, assuming (as the evidence from New Zealand demonstrates) that changing attitudes towards schizophrenia specifically will take a longer term campaign than attitudes towards depression. They assumed only modest changes in attitudes and ran economic modeling to identify cost benefits.

They calculated the cost-saving of a reduction in negative attitudes towards people with depression was £164 per person with depression, or £4.26 per adult in the whole population. Similarly in relation to negative attitudes towards schizophrenia, the research found a cost-saving of £4.51 per adult in the population. Individual organisations – and therefore the nation - will achieve greater productivity when mental health problems are dealt with effectively and without shame or discrimination in the workplace.

The new English initiative is called *Moving People* (<http://www.movingpeople.org.uk/>) and was able to draw on this evidence to seek private funding. The initiative is only nine months old, and represents the single largest grant from private sources to a mental health NGO in British history. *Moving People* receives £16M from the Big Lottery Fund and £2m from Comic Relief – the single largest grant ever made by this funder. *Moving People* is comprised of 28 local projects, the evaluation, and six national projects which are:

- The high impact social marketing campaign – this is still in development, and will be informed by Stigma shout, a recent piece of research showing 87% of people with mental illness report discrimination
http://www.rethink.org/how_we_can_help/campaigning_for_change/moving_people/stigma_shout.html
- Newsletters, emails and information delivery;
- Open UP – the project giving people with direct experience of mental distress the skills, tools and support necessary to directly challenge stigma and discrimination
<http://www.openuptoolkit.net/home/index.php> ;
- Get Moving! – an annual event to encourage physical activity for mental health;
- Training – training of teachers and medical students by people with mental illness around discrimination
- Service User and Carer Advisory Group – to advise the entire project and provide input to the management group.

The MovingPeople campaign – soon to be re-called Time2Change – includes physical activity as a key component in the localized projects. This provides some interesting opportunities and limitations during the roll-out phase. As the whole project is less than one year old and has yet to launch its mass media component, many are still waiting to see the impact of this initiative in England.

4.2 POLICY INFLUENCE

The key organizations who were undertaking policy influence work that I spent time with were Platform and the Mental Health Foundation in New Zealand, Mental Health America of Los Angeles and Mental Health America in Washington DC, Canadian Mental Health Association BC Division and Ontario Division, and Mind in London.

In all the countries I visited there was considerable activity occurring to transform mental health systems and influence policy. While definitions and specifics differed, generally speaking the vast majority of this reform work was focused on achieving a more community-based, recovery-oriented mental health system and ensuring better outcomes from clinical services. There was a remarkable similarity of goals, broadly defined.

Perhaps the most surprising discovery was the limited sharing of information between these organizations. The Canadian and American mental health systems are very fragmented and uncoordinated: much service delivery and planning happens at a local level, and states or provinces have considerable control over the direction and delivery of mental health services. This means a national perspective is often lacking and many advocates do not have access to national data or even basic information on mental health expenditure. In North America I found pockets of excellence, but limited use of these demonstration projects to change the overall system (with the exception described below in California).

While Australia, New Zealand and the UK may have clearer national plans and targets, this does not mean implementation of reform is uniform across these jurisdictions. In none of the interviews did anyone in these countries mention research or evaluation documents which described *how* NGOs were trying to reform mental health systems. It may well be that this work exists, or could have occurred in academic institutions, but the people planning and delivering policy influence did not refer to any evidence base.

None of the people I spoke with had documented their overall approach to reform, let alone started to share their learnings with organizations in other states/provinces or other nations. While specific campaigns are well planned and sometimes reviewed, the overall approach to change appears to be intuitive and based in the skills of individual leaders. It became clear as I moved between jurisdictions that advocates would draw considerable benefit from sharing their experiences and developing a clearinghouse of system reform initiatives.

Even though Canada, New Zealand, USA and UK are all English-speaking OECD nations, there are significant differences in terms of their social, health and political systems. In terms of policy influence, the mechanisms and levers available vary considerably from those in Australia. The following examples demonstrate how these differences can impact on the practice of policy influence in mental health.

4.2.1 National Policy Influence from Mental Health America

At both state and federal level America has a separation of powers, so the Executive is not part of the legislature. Instead of the Governor or Governor-General being a figure-head with predominantly a ceremonial role as in Australia, American Governors and Presidents are directly elected by the people separate to the parliament. The Governor/President appoints all members of the Cabinet (who are also *not* members of parliament) and has veto powers over legislation coming from parliament. The parliament, however, can also override the veto of the President/Governor if more than 66% of members support a bill.

For example, at the Federal level the Congress has passed laws to enable funding for community mental health centers, mental health support to children in the care of the state, and funding for some disability supports. Much of this is delivered through a program called Medicaid. The President, however, wants to reduce spending on health and social services because this is seen in the USA to create dependence, and so introduced regulations intended to amend the legislation passed by Congress, that will eradicate the capacity of states to bill Medicaid for these types of services. In summary, through the creation of a regulation, he is attempting to remove most federal funding for community based psycho-social interventions.

The good people from Mental Health America who work “on the hill” (ie their focus is legislators in Congress and the President and Cabinet) are used to fighting cuts to Medicaid. They have established a coalition with Disability Policy Collaborative, American Child Welfare League and the umbrella agency for all community mental health centers to fight these regulatory changes. They needed 66% of both House of Representatives and Senate to pass the bill that would stave off the President’s actions and override his expected veto. They convinced 75% of member of the House of Representatives to support a bill overriding the President’s regulations last year, and I attended a meeting with this group and a conservative leader in the Senate to try to get two-thirds of Senators to also vote it down.

Despite their good work, this may still not occur because time is running out before the Presidential election and there are very few “legislative vehicles” which will be going through the Senate before the election to which they can attach this reform. [STOP PRESS: while MHA did not get two-thirds of senators to pass the bill, with support of affiliates and partners they did get a temporary victory through legislation which delays implementation of the President’s regulations.... For now].

Preventing an initiative is difficult but getting a positive mental health measure in place at the national level is more challenging. This can occur by working with appropriations and authorisation committees – for both House and Senate. Appropriations committees are important as they allocate funds, and Mental Health America is leading the Mental Health Liaison Group – a collaboration of more than fifty NGOs interested in mental health – to put forward their views on forward budget allocations to health appropriations committees.

Another approach is to work with authorization committees which can investigate certain matters and produce reports. The lobbyists at Mental Health America (MHA) tried to get key new ideas into “report language” which is the first step towards a bill. The American system of government is complex and the many checks and balances and cross-party deals make negotiation extremely slow. The passing of a budget by the Congress, even with approval of the President, is no guarantee that funds will flow to enable the activities they have supported. Similarly statements by the President and endorsement of reports such as the New Freedom Commission (<http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm>), while significant, do not guarantee implementation.

The team on the hill is just one part of Mental Health America (www.mentalhealthamerica.net), with a much larger team focused on health promotion, communications, research and policy development in Alexandria, Virginia – just across the Potomac. This research, policy and media work supports those doing direct political advocacy.

4.2.2 Other Policy Actors in USA National Mental Health

Given the significance and complexity of decision-making by Congress and the President public sector agencies have developed their own NGOs to push for additional funding and policy reform. This appears a uniquely American phenomenon which I did not observe elsewhere. I called them GONGOS: Government Owned Non-Government Organisations, and their participation in policy advocacy in this manner is shocking for an Australian.

For example, the Californian Mental Health Directors Association represents Directors of Mental Health at the local government level across California. They commenced to develop and deliver training with a view to service improvement, but increasingly play an active role in policy influence. Similarly at the national level, the National Association of State Mental Health Program Directors represents mental health executives of all 50 states, 4 territories and the District of Columbia. Apart from ensuring their slice of the mental health budget, NASHPD (<http://www.nasmhpd.org/>) has advocated for reduction and eradication of seclusion and restraint. These agencies are very well resourced given their members are able to make significant financial contributions.

At the other end of the spectrum is the National Coalition of Mental Health Consumer/Survivor Organisations (<http://www.ncmhcsso.org/>) represents state and regional networks of consumer/survivor organizations across America. Lauren Spiro is their sole worker and Director of Public Policy. Despite extremely limited resources this organization has also visited many electeds in DC, and managed a presence at party election conferences.

In 2006, for the first time in the history of the United States, a national coalition was formed to be the voice of people with the lived experience of mental health recovery. The

National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO) foundational values which inform all their work are:

“Recovery: Recovery is possible for everyone. To recover, we need services and supports that treat us with dignity, respect our rights, allow us to make choices, and provide assistance with our real-life, self-defined needs.

Self Determination: We need to be in control of our own lives.

Holistic Choices: We need meaningful choices including a range of recovery oriented services.

Voice: We must be centrally involved in any dialogues and decisions affecting us.

Personhood: We will campaign to remove stigma and discrimination.”

There are 36 member organizations (32 consumer-run statewide organizations and 4 national Technical Assistance Centers). Efforts are underway by the Coalition with the Technical Assistance Centers (one of which is housed in Mental Health America) to organize statewide consumer organizations in the other 18 states not yet represented.

At the NCMHCSO’s second annual face to face conference policy priorities and use these in meetings with elected officials. NCMHCSO works in collaboration with organizations and coalitions such as the Bazelon Center for Mental Health Law (<http://www.bazelon.org/>), the American Association of Persons with Disabilities, MHLG and the Campaign for Mental Health Reform. While small in resource the NCMHCSO has a strong claim to being the voice of consumer/survivors in America, and are beginning to impact on DC politics.

There are many other policy players at a national level in America, all of whom I could not spend time with in ten days! The most significant exception is the National Alliance for Mental Illness (NAMI) which has a significant presence in policy influence and a resource base in mental health advocacy.

4.2.3 Policy Influence in California

In the United States mental health services are directly delivered and/or contracted by local government, not the state government, so there is significant disparity and lack of coordination across and between county mental health services.

At a state level California demonstrates what can happen through determination and an alignment of influence. Mental Health America of Greater Los Angeles (<http://www.mhala.org/>) or MHALA – one of 320 affiliates to the national organization Mental Health America - is an advocacy organisation that for decades had undertaken only policy influence work.

In 1988 new legislation authorized a pilot program to investigate an integrated service model of programming, not unlike the ACT programs started in Madison, Wisconsin, but with the social support of a Fountain House (New York). MHALA applied to be the pilot

agency in the conviction that the best advocacy would be to “build the better mousetrap”. The grant was won and the MHA Village opened in January of 1990

The county mental health service wanted to see if providing the funds ordinarily spent per person on hospitalization to an NGO, could produce better outcomes at less cost. The state wanted to see if a case rated system could produce better outcomes without spending vast sums of extra money. MHALA were allocated the dollar amount per person required to maintain a person in an existing conditional prison release program (about \$15,000 per person per year), but they could use it to provide whatever service type they wanted – including hospital services if necessary which they purchased. As important, they did not have to bill for services in order to receive payment. Twenty years later an amazing service continues to meet the recovery needs of clients living with mental illness who come from homelessness and jail. The advocacy strategy worked, as many began to copy the service model and its success sustained calls for system wide reform. That is, people began calling for services that operated like The Village. MHALA had successfully created a beacon of good service and service reform.

And this demonstration or path finder project also produced evidence of what works. Evidence used by Assemblyman Darrell Steinberg and Rusty Selix, the CEO of the California Council of Community Mental Health Agencies, to establish a ballot initiative (i.e. voted by referendum from the general population) called Proposition 63. This California wide organization included service providers, consumer groups and family/carer agencies. Proposition 63 proposed a surcharge tax of 1% on personal income over \$1M, to provide funds for community-based mental health services, mental health promotion and an anti-discrimination campaign. In California, that’s a LOT of money: in the 2007-8 fiscal year the initiative produced about \$1.5 billion US.

The referendum was won by 53% of the popular vote after a massive grassroots campaign, and the funds will be allocated through a complex arrangement between the state and county governments. Rusty Selix attributes success to a strong member support, evidence of alternatives that work, and the interest and strenuous support of an influential Californian Assemblyman, Darryl Steinberg. The existence of a well run community mental health umbrella organization with grassroots support, an evidence and practice base of how things could be improved, and a supportive political leader, all combined to make Proposition 63 a reality. It is now called the Mental Health Services Act: a great achievement.

But you guessed it bureaucracy raised its ugly head. State level bureaucrats have managed to insert enough rules and regulations and a cumbersome granting process so that three years later at least half of the funds approved are yet to be allocated.

The initiative established a body called the Oversight and Accountability Commission (OAC) to ensure the funds are appropriately spent. The OAC provides accountability and oversight, but it was slow to get organized and is still feeling its way toward effective oversight. Like so many American political institutions there is a focus on participation

and public debate, so the OAC meets publicly to scrutinize the massive Mental Health Services Act expenditure.

This process was again fascinating to observe: a government executive committee deliberating in public (i.e. with an audience of about 50 people) in Bakersfield. The meeting proceeded in a slightly bureaucratic manner until question time was opened. The Representatives of the California School Health Centers Association told me they had been coming to OAC meetings for more than two years trying to get them to allocate funding for health promotion in schools: funding which had already been approved through the Californian legislature.

The California Network of Mental Health Clients made an impassioned plea to Commissioners of the OAC to support the flow of resources, especially in terms of mental health promotion and anti-discrimination initiatives. This network had strongly participated in the campaign for the Mental Health Services Act and was now watching as the California Executive Branch (the Department of Mental Health) managed to tie up resources from the MHSA. In America winning the fight to get funds approved, does not mean the struggle to improve systems is over!

4.2.4 Contemporary Policy Influence in Canada

The Mental Health Commission of Canada is a new autonomous government-funded body headed by former Canadian Senator Michael Kirby, with a board comprised of provincial government appointees, Aboriginal leaders and community organizations. The MHCC has a mandate to deliver:

- a national campaign to confront stigma and discrimination;
- a national mental health policy and plan (Canada does not have one);
- knowledge transfer and exchange in mental health.

The MHCC has also successfully bid to the national government to deliver a \$110M mental health homelessness demonstration projects with wrap-around research.

The MHCC is *not* an advocacy body, but the vision of Mike Kirby is that it will develop a strong grass-roots movement calling for social change in mental health (http://www.mentalhealthcommission.ca/documents/EN_Kirby_GIbandM1_Jn28_08.pdf). Most stakeholders I spoke to agreed Mr Kirby was the man to deliver on this agenda. He has a long political career as a Senator and Minister, enjoying support from both sides of politics, and has worked as chief of staff for Premiers and Prime-Ministers.

Again the political context impacts on influence strategies. Within the Canadian federal system the national government has limited capacity to determine health spending and priorities, while the provinces have significant impact. Mike Kirby understands that pressure for reform must come through provincial authorities, and so the MHCC – much like the New Zealand Commission – is creating leadership and direction for national reform, through a two way process of exchange with grassroots constituents.

How this plays out with existing organizations is yet to be seen. I spent time with the Canadian Mental Health Association – in both British Columbia and Ontario – and their structure reflected the weakness of national mental health policy. Both the BC division and Ontario Division of CMHA were undertaking significant work trying to influence the system, as well as deliver services. The national CMHA was very weak. The CMHA is over one hundred years old and the MHCC is just nine months into its history.

Michael Kirby is a passionate, intelligent and extremely well connected advocate – he has business and political connections across the spectrum and the country. In all the countries I visited there was no political leader of such prominence who was so dedicated to the improvement of outcomes for people with mental illness. The MHCC has operated for only nine months but I believe it will become a significant force for change in Canada.... Watch this space.

The Mood Disorders Society of Canada (www.moooddisorderscanada.ca) is led by Executive Director Phil Upshall who is playing a significant role as an advisor to the MHCC, within his own organization and also with the Canadian Collaborative Mental Health Initiative. Phil is also involved in anti-stigma and mental illness awareness raising initiatives, and the Canadian Alliance on Mental Illness and Mental Health (<http://www.camimh.ca/>).

Connie McKnight is the National Executive Director of the National Network for Mental Health (www.nnmh.ca) which brings together consumers and consumer organizations across Canada. This is the only national consumer organization in Canada which is pan-mental illness (ie does not represent people from a specific diagnostic group). The Network actually grew out of the Canadian Mental Health Association, becoming independent in 1991. The Network is also the facilitator and founding member of the Canadian Coalition of Alternative Mental Health Resources (<http://www.ccamhr.ca/>). The Network has chose to take an arms-length watching brief on the MHCC and does not currently participate in any of its various committees or reference groups.

4.2.5 Mind

The approach of Mind in the UK to mental health was very different to the CMHA's in Canada or Mental Health America and its affiliates in the USA. Mind is more similar in policy terms to the Mental Health Foundation of New Zealand and Platform Inc in NZ. Unlike Canadian and American NGOs which receive significant amounts of their funding from drug companies, Mind has a policy position against accepting any income from pharmaceutical companies. Mind does not use the term "Mental illness" as it gives a disease orientation and understands mental health from a social perspective, not a biological or medical paradigm. This made its positions markedly different from North American agencies, and closer to the philosophies of NGOs in New Zealand.

Its strategies for change were quite similar, but it had the clearest articulation of any agency I visited about the need for reform and a clear organizational structure to deliver this. Mind has a media team, a policy team, a campaigns team and research capacity.

While Mental Health America had three staff dedicated to working “on the hill”, Mind had only one direct parliamentary liaison officer. Across the agency there was a high commitment for the need to speak out about mental health issues and to reform the system.

Mind also had an internal network of mental health consumers: MindLink, which enables people with the lived experience to lead policy development and priority setting. Mind was proud of the high percentage of board members and staff with direct experience of mental illness (more than 50% of staff and board have experience of mental illness). While North America had an incredibly high number of vibrant and successful consumer-led or peer-run organizations, Mind seemed to have integrated consumer leadership successfully within their agency, without specifically being established as a separately incorporated consumer group.

However the key difference with Mind was the strong *integration* of the various work teams across the organization. In some North American agencies it was not uncommon to discover that someone in the policy team was undertaking similar work to someone in the marketing or campaigns team: but they were not always aware of this and working together. Mind demonstrated considerable focus on trying to ensure the efforts of their large staff – and Mind was the largest organization I visited by far – were integrated and mutually reinforcing.

While advocates in all nations articulated a similar pattern of policy influence, the people I spoke to at Mind all seemed aware of this pattern and each team’s role. The media team are focused on responding to media inquiries and tabloid mental health coverage, but also to ensuring mind’s priorities and language were well communicated to the press. The policy team (which included a separate team working on cultural diversity and inclusion) cross-hatched a wide number of policy areas, constantly balancing the need to be comprehensive (“mind is asked to have a view on everything!”) while thinking about strategic matters (ie could we get this funded now?). The policy team undertook significant research work to support reform goals. The campaigns team worked consultatively with policy and media teams, and they were all backed up by an impressive information and research unit, and legal team.

This is a rosy picture of the organization and I’m sure there are many flaws which do not become apparent to someone who sits in an organization for such a short period of time. However the work of mind was much more integrated than the agencies of North America, which could sometimes appear as a group of consultants undertaking projects that did not always lead in the same direction.

Perhaps as the largest agency I visited, Mind simply had the organizational resources and capacity to ensure integration of their policy influence work. The challenge was also to ensure this head office activity is backed up by the team that connects with all the local mind agencies (over 200 localized and separately incorporated Mind associations across England and Wales), MindLink which is a network of consumers across the country, Rural Minds, and as I mentioned, Diverse Minds. The marketing and fundraising teams

also had a clear understanding of Mind policy activities and general strategic priorities to ensure their work was consistent with the organisation's mission.

4.2.5 Mental Health Foundation of New Zealand and Platform

Platform (www.platform.org.nz) is the peak agency representing non-government mental health service providers in New Zealand. It receives membership income and income to undertake specific contracts. While its focus is the non-government, non-profit sector, it attempts to influence the overall mental health system. Much of its policy work has been to draw attention to the value of civil society and the approaches of non-government organizations in mental health and addiction services.

The Mental Health Foundation of New Zealand (www.mentalhealth.org.nz) is predominantly a mental health promotion agency and is probably one of the best known mental health agencies in New Zealand.

Both organizations undertake policy influence and the similar pattern of research, policy solution development and campaigning occurs in these organizations. The key differences being that these agencies are much, much smaller than northern hemisphere counterparts. Thus activities which might be spread across ten people at Mind, for example, would be the responsibility of one person, who also had significant role in managing service delivery.

The New Zealand context is significantly different to any other country in three respects:

1. The New Zealand Mental Health Commission had exercised significant leadership to reform the mental health system and produced many resources that articulated the values and vision of the reform direction;
2. More than 30% of mental health services are delivered by non-government organizations which has produced a far greater diversity of responses and the beginnings of a “mainstreaming” of community-based alternatives to hospitalization;
3. There are significant numbers of organizations run by Maori, and significant numbers of organizations run by consumers. The voices of Maori and people with lived experience simply cannot be ignored in the New Zealand mental health system.

The Foundation has drawn on this rich experience through the creation of its Mental Health Advocacy Coalition or MHAC which includes representative from Platform, professional associations, consumers and culturally specific populations. This group has recently released a policy document which is probably the most impressive and comprehensive documents in mental health I saw throughout my travels. “Destination Recovery” charts the path for mental health systems transformation and can be downloaded at <http://www.mentalhealth.org.nz/resources/Destination-Recovery-2008.pdf>

It's the best thing I've read on mental health systems reform.

4.2.6 What Does the International Experience Tell Us?

There are significant differences between nations on how organisations undertake policy influence given their very different policy contexts, social institutions, histories and so on. While there are many similarities, everything changed when I shifted across national boundaries.

Despite these differences, there remain some common themes and lessons learned from my brief glance across these four nation's contemporary practice. These include:

- The pattern of policy influence was remarkably similar across agencies: Research – Policy Development – Agree a Solution – Campaign. All engaged in research on an issue and produced a report/s. This research included policy work with stakeholders on solutions as well as survey or quantitative research data to substantiate or document the problem. Documents were produced that articulate the problem and a practical, achievable solution. Campaigns were then constructed to achieve these solutions, and media and politicians were engaged to press for implementation of the solutions. The development of campaigns strongly considered media opportunities and the general public as the audience. Members and others were also engaged to press decision-makers for these solutions and to engage in media activity to highlight the problem. Mind appeared the most successful at integrating these activities across the organization to focus on the achievement of specific goals.
- Collaborations, partnerships, networks and consortium were widely used strategies. In the UK the very broad coalition which was formed to prevent some very restrictive mental health legislation around compulsory community treatment was oft-cited as successful. Similarly the Mental Health Liaison Group in the USA had been successful in maintaining federal grants programs, and the development of Proposition 63 came through collaboration. These approaches often brought together organizations who have fundamentally different philosophies, but are able to work together to achieve some specific goals which are mutually supported.
- The media is key. Without your issue being prominently discussed in major media it becomes extremely difficult to engage politicians, and also challenging to engage the public or motivate members and branches. Mind in the UK employs a team of four media staff, Mental Health America in Washington DC employed three media staff. All agencies spoke of the difficulty of engaging media in a positive agenda on mental health and the challenge of how to respond to media fear mongering about people with mental illness in the community.
- All agencies are challenged by direct political engagement: community mental health advocates find it difficult to get past senior public servants and/or advisors to speak directly with elected officials. In New Zealand Platform and the Mental Health Foundation often influence public servants but struggle to directly engage

ministers or other members of parliament in advocating better mental health policy. In the US it is extremely difficult to directly engage congressmen and women and the Presidents staff unless you have a big budget and access to professional lobbyists. Senator Kennedy here is a notable exception. Some would say unless you can bankroll a re-election campaign your influence will remain minimal. In Canada some believed working quietly with senior public servants was useful and sometimes – given the turn-over of Health Ministers – more productive. The involvement of Michael Kirby at the Mental Health Commission of Canada is probably the best example I saw of senior political figures committing to the cause. The commitment of Darrell Steinberg in California is another example with very positive results.

- Specific, well-researched policy solutions are imperative. Policy influence is most successful when the solutions advocated for are detailed, achievable and realistically costed, and if possible backed up by research. Vague demands for a “more recovery-oriented system” for example, are difficult to implement and so can often fail to influence practice or policy. The MHA Village example demonstrates the power of Pathfinder projects to influence policy: the “just do it” approach.
- Everyone might support your cause: don’t burn bridges, and remain persistent. I heard many stories of senior figures re-appearing in new roles, and politicians or pundits who were thought to have lost all influence, suddenly returning to power.
- Connect local and national – if you can support members and/or affiliates/branches and their memberships to use your campaign demands and make similar calls, there is greater chance of success. The more support for an initiative is perceived as broad-based, the more attractive it becomes to electeds and other key decision-makers. American agencies seemed most successful in organizing common campaign messages and strategies across affiliates and/or with partner organizations.
- No one refers to a body of evidence relating to mental health systems reform, and there is very limited sharing between organizations about their learning from policy influence. This is true even in nations that are similar and proximate, namely USA and Canada or Australia and New Zealand.

These are merely my reflections after eight weeks travel in a minority of the organizations active in policy influence. I believe, however, all of this points to the value of a Centre for Mental Health Systems Reform. One activity could be a clearinghouse for information on mental health systems reform where ideas and experiences can be shared. It could also be a place where an evidence base could be developed to guide future efforts. An international centre for mental health systems reform could bring together practitioners from developed and developing nations, and from Indigenous perspectives to share knowledge and skills, and build an international network of people working for systems change.

4.3 FUNDRAISING

There was again significant diversity amongst these organizations in terms of their social and political contexts, values and histories, but there were remarkable similarity in strategies. The main difference was the philanthropic traditions of various countries, and the extent to which drug company funding was acceptable. In summary, all the following approaches to fundraising were used:

- Internet based direct donation – all agencies were working on internet giving strategies and identified this as the future growth area;
- Direct Mail Marketing – this was used by most agencies, but the profile of business reply paid giving were generally older people, and often loyal members/donors. These donors have been with agencies for a long time, and lists have taken many years to develop;
- Sponsorship – one-off funding for specific products or activities
- Contracts – funding for specific projects (from Foundations or Government sources) sourced by response to tenders or applications
- Events – gala dinners, comedy nights, conferences
- Sales – training events, resources,
- Businesses – consultancy, education, commercial (eg Mind has network of opportunity shops across England)
- Planned giving or bequests – there was not significant work in this area
- Face to Face fundraising – meeting with high net wealth individuals directly and cultivating their commitment to a cause and/or organization
- Cause related marketing – attaching a brand or product to support for a cause.

There was significant overlap between an organisation's policy influence and its fundraising and also social inclusion initiatives. Often the one activity was in fact contributing to all three areas. Certainly fundraising and policy influence are significantly impacted by the public recognition of the organization. The longevity of the organization can also impact on public recognition: forty years of history does create greater awareness even with minimal marketing than a newly emerged organization. All the agencies I visited had decades' long histories, some more than one hundred years, although under different "brands" through name changes and/or amalgamations.

While all agencies identified the difficulty of mental health fundraising, this was by no means an insurmountable barrier to development. All agencies were drawing significant percentage of their incomes from philanthropic sources, varying from 15% to 35%.

The two recurring issues mental health fundraisers spoke with me about were:

1. Lack of understanding. Many in the general public have no understanding of what mental illness is, and often confuse it with intellectual disability or some other behavioural disturbance. Their market research tells them the public struggle to understand what mental illness is and can understand it to mean anything from "feeling blue" through to psychosis.

2. Stigma – mental illness is rarely perceived as “cuddly” issue. It does not immediately get people to put their hands in their pockets as happens when fundraising for children or animals. Given media fear mongering around “escaped lunatics” or “insane killers” there is often not a sympathetic perspective from the public once they become clear the agency provides support to people who experience significant psychoses.

The link here between anti-discrimination or social inclusion campaigns and enhanced fundraising initiatives is obvious.

However all agencies had devised means to move past these obstacles and were successful in raising funds from the general public in a variety of ways. All agencies were generous in sharing their direct mail and other marketing copy from their campaigns. While it is beyond the capacity of this report to include all this copy, I have recommended the development of a network which might enable such international sharing of product.

The third difficulty that was identified particularly at Mind, was the challenge of fundraising for advocacy rather than services. Across all nations all these organizations provided services: they were not simply stand alone advocacy agencies. As a result, most directed their fundraising activities towards resources for services and few had specific activities for advocacy efforts. Market research done for Mind reinforced that public was better able to understand an “ask” made on the basis of providing services rather than one based on the need to advocate for more or better services.

In retrospect I think more might have been learnt about fundraising for advocacy initiatives through contact with environmental and human rights organizations. Given all the agencies I spent time with actually delivered direct services to people in mental distress, they were not directly challenged to develop fundraising initiatives focusing the “ask” on support to advocacy alone.

5. CONCLUSION & FUTURE ACTIONS

5.1 SOCIAL INCLUSION CAMPAIGNS

There is now a significant international practice and evidence base that indicates social inclusion campaigns work, with measured demonstrable reductions in negative public attitudes towards people with mental illness in New Zealand, Scotland and England. Economic modeling from the Institute of Psychiatry, Kings College London and London School of Economics has identified significant, quantifiable returns on investment for any Government considering an investment in social inclusion campaigns.

We know that to work these campaigns must have:

- A high profile national social marketing campaign which presents positive and normalizing images of people with mental illness;
- A diverse range of grassroots community projects which provide opportunities for people to have direct contact with people with lived experience at a local level;
- Leadership from people with mental illness; and
- Strong evaluation and research components to ensure development over time.

With the Canadian social marketing campaign under development, Australia is the only English-speaking OECD Nation that has no anti-discrimination campaign in place, and no plans from Government to initiate one. This is a significant gap, and a surprising lack of development given Australia had the first mental health anti-discrimination television advertisements back in the early nineties.

5.2 FUNDRAISING

While there are many challenges to raising funds from non-government (and non-drug company) sources, it is possible. In New Zealand – where there is a small population and very undeveloped culture of philanthropy – organizations are successfully raising funds. In North America and the UK there has been considerable success in raising private funds to support mental health. Funding for mental health advocacy is particularly difficult, but still achievable.

The solutions are:

- Invest in this area of work and have a long-term view on returns;
- build slowly and ensure positive experiences for all donors;
- Think creatively about messaging and imaging;
- Ensure fundraising integrates with social inclusion and policy influence work;
- Partner and collaborate with others.

5.3 POLICY INFLUENCE

Across all these nations community organizations are working hard to reform mental health systems, often to re-orient these in the same way: towards more community-based, recovery-oriented systems. An international centre for mental health systems reform would enable a sharing of the existing body of knowledge, and the development of an evidence base and framework to guide future work.

5.4 DISSEMINATION OF FINDINGS

This report will be posted on the Churchill Fellowship website (<http://www.churchilltrust.com.au>) and the Queensland Alliance website (www.qldalliance.org.au). A shorter version may be published in hard copy.

Three twenty-minute presentations have been developed to highlight the key learnings and recommendations from the Fellowship. This has already been presented to senior executives in the Queensland Public Service and the National Advisory Council on Mental Health in Australia. A workshop on findings will occur at the World Mental Health Promotion Conference in Melbourne 2008. Presentation to the Queensland Health Minister's backbench committee will occur in October, and a series of community forums across Queensland and some in other states, will occur this year.

At time of writing the Mental Health Council of Australia is considering how to support the findings of this study tour and disseminate them to its national membership.

The Queensland Alliance is advocating strongly for a Social Inclusion Campaign on Mental Health. The Queensland Alliance through member consultation has identified stigma and discrimination as the top priority issue for people with mental illness. Discrimination impacts on people's capacity to recover, their ability to seek resources, services and treatment to alleviate mental distress, and indeed the ability of the sector generally to attract increased resources and retain high quality staff. The Queensland Alliance has shown the *Like Minds* Campaign to the Health Minister and the Treasurer, and staff of the offices of the Federal Health Minister and the Prime-Minister.

The findings around mental health policy influence are of interest internationally. The Queensland Alliance and the Mental Health Council of Australia are keen to work with key organizations around the world to improve our approach to mental health systems reform. The International Institute for Mental Health Leadership convenes in Brisbane in 2009 and the Queensland Alliance will be attempting to place this issue on the agenda. Similarly the Charter for Mental Health Promotion and the London Conference on Anti-Discrimination are forums in which the development of an international centre might occur. The World Mental Health Association and the Carter Center are two international agencies who may be interested in supporting the dissemination of this work and the implementation of recommendations.

6. RECOMMENDATIONS

6.1 A Mental Health Social Inclusion Campaign in Australia

Australia is the only English speaking OECD nation without a national anti-discrimination campaign in mental health.

This must be addressed by community, private sector and government agencies working together at state and national levels to campaign for the social inclusion of people with mental illness. A Queensland or Australian Social Inclusion Campaign is urgently required.

This campaign must include:

- A public marketing campaign promoting positive images of people with mental illness and demonstrating social inclusion in action
- Resources to local community agencies to support broad diversity of direct contact strategies between the public and people with mental illness
- Leadership from people with direct experience of mental illness
- Evaluation and research activity to refine the initiative and demonstrate value.

6.2 An International Centre for Mental Health Systems Reform

In Canada, New Zealand, USA and UK many organizations are calling for a more community-based, recovery-oriented mental health system. There are diverse experiences and successes in this global attempt to reform mental health systems which are not currently shared and not contributing to creation of an evidence base. An international centre will:

- Be a clearinghouse for information on reform strategies and successes;
- A coordinating agency to enable and encourage learning through exchange and working together on virtual projects;
- Leadership development and training for advocates working to improve their national mental health system.

6.3 Fundraising for Mental Health Advocacy – Virtual Network

Fundraising can be an extremely competitive activity where sharing strategies and approaches may not seem in the best interests of the agency. I was over-whelmed with the generosity and openness of all the professional fundraisers I met during this Fellowship. A virtual network of fundraisers in mental health advocacy will support a global community of practice to inform and improve our collective efforts.