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WHAT DOES THE ACT MENTAL HEALTH
CONSUMER NETWORK DO & WHY?

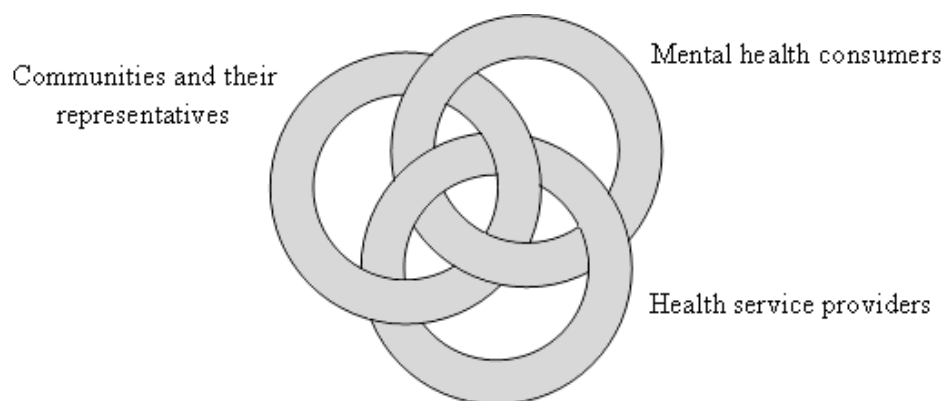
**A big picture explanation for making advances in
mental health reform and building an inclusive community**

In partnership with

ANU College of
Medicine, Biology
& Environment



What Does the ACT Mental Health Consumer Network Do and Why?
A Big Picture Explanation for Making Advances in Mental Health Reform and
Building an Inclusive Community



A cooperative community for positive change

Cover image, *Portrait of a Consumer Representative*, created by Michael Firestone.

Gee, A., McGarty, C., & O’Kearney, R. (2009). *What Does the ACT Mental Health Consumer Network Do and Why? A Big Picture Explanation for Making Advances in Mental Health Reform and Building an Inclusive Community*. Report on research findings, The Australian National University, Canberra, Australia.

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About the Authors

This research project was conducted by Alison as part of her PhD (Clinical Psychology) research program. Alison has been studying and researching the stigma of mental illness since her Honours thesis in 2003. Alison is also a clinical psychologist.

Craig is the Director of the Social Research Institute at Murdoch University and is a leading researcher in social psychology. He has many published books and papers in peer-reviewed journals and has supervised many research projects in group processes and social change.

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Author's Statement

by Alison Gee

My awareness of the significant impact that stigma can have for people with mental illness was sharpened during my Honours study in 2003. Since then, I have been researching ways to overcome the stigma of mental illness. My approach to this problem has developed into a community-based perspective, in particular taking into account the groups that people belong to and the meanings of those groups to individuals. Some of these groups can be strong motivators for people to behave in ways expected by the group. For example, in our previous research (see Gee, Khalaf & McGarty, 2007), we facilitated group discussions among first year psychology students who identify themselves as supporters of mental health advocacy (this group is interesting because they are members of the community who are also prospective mental health workers). We found that these discussions can help to increase the willingness of people to take action to support the aims of mental health advocacy.

This is an encouraging finding, so it makes sense to look at groups within the mental health advocacy movement more closely, not least because research on the stigma of mental illness must involve those who are affected by that stigma. In addition, our previous research suggests that providing information to people about the mental health advocacy movement and the existence of consumer-run mental health advocacy groups such as the ACT Mental Health Consumer Network (ACTMHCN, the Network) can help to improve attitudes about people with mental illness by presenting them as an organised and proactive group of people rather than the negative stereotypes of being lazy, disorganised and passive (Khalaf, 2002; see also Gee, Khalaf & McGarty, 2007).

All of the above has led me to the current research project to better understand the ACT Mental Health Consumer Network's approach to stigma and advocacy. A second aim of the project was to seek members' views about a framework for defining relations between the key players in the mental health sector.

My engagement with this project has demonstrated to me that the richness of the ACTMHCN is found in the people and welcoming atmosphere of this group. I have tried to convey this richness in this report and see it reflected most strongly through the interviewees' own comments. This report was written to present the results of an objective research analysis on consumers' views about mental health reform and as such

has stayed true to reporting ACTMHCN members' own comments. I hope the analysis shows where consumer advocates are coming from, what the consumer perspective is about and what the Network is working to achieve in relation to mental health advocacy. I hope it also conveys the positive spirit with which the Network functions. It is clear the relationships of consumers (particularly advocates) with health providers and policy makers have a difficult history. It is also clear there is a strong desire at the ACTMHCN to move forward to work more effectively with health providers (and policy makers) on equal footing rather than wanting to take over, stamp down or push health providers (or policy makers) out. Hopefully, this message is strong in the report and if it is, I hope this report will be of interest to consumers, health providers, governments and members of the general community in coming to develop solutions for the future.

The ACT Mental Health Consumer Network's Statement

by Jane Williams in consultation with other Network members

I have been a mental health advocate, consultant and representative for many years now. I have to admit that at times I am like a dog that keeps nipping at the ankles of the legislatures and policy makers. It feels they were always reinventing the wheel, at great expense, just changing colours. As time went on, I just became more cynical. About five years ago, things started to change and I became a little hopeful. I found the Network. I was a member when it first started, but moved to other avenues for change. But there it was, The Network. Struggling a little, but so full of hope and willingness, they let me run with my ideas and gave me a home, an anchor to secure myself when times were hard. I also had to learn to be a little diplomatic rather than bull-headed.

This project has picked up on what we have been trying to achieve. The report can be read through many different lenses, depending on who you are and your background. I am confident that it could be read by people from so many different fields who are at the coalface or have just a small interest in what people with a mental health issue can, and in fact do, achieve. Sometimes we representatives are so busy jostling to get our voices heard, that we need to remind ourselves there are other members and staff who just try to get people to feel empowered enough to be able to take those steps to speak up themselves.

A good overview of where the ACTMHCN is doing well is provided in this paper. It also shows where we have known we need to pick up loose ends. This paper is also about stigma. Somehow, we still have to knock down the old stereotypes of 'mad people' and that we are all violent and truculent. The worst is that statement dragged out almost by the minute, 'we are doing this for your good', as though we are brain dead. In fact, our lived experience allows us to contribute our valuable knowledge.

This paper outlines what a person is capable of, despite the lack of faith from others. Then when two or more people get together that are of the same desire, it shows what an organisation such as ours is capable of achieving.

There have been a few doubting Thomases where the Network has been concerned. But with hard work and determination we have changed that and achieved more than many people, and other organisations, thought we could.

There are a lot of organisations that are working on decreasing stigma, but still the message doesn't really get through. On the bright side though, we have come a long way in the last few years especially, in chipping away at the edges. As a Network, the fact that we are now looked at to provide representatives and consultation from a lived perspective to new areas shows that we are still being noticed, and that people want to know what we are so passionate about.

The very content of this paper shows that we are not perfect; but by goodness, we are trying. We are thankful for that. It also allows us to revisit the old aims and goals. I feel that this project came at a good time for the Network. I am glad that we could be so open to those who were interested in what we have achieved, and also what we need to look at more closely.

I would also like to see the Network have this type of project revisited in a couple of years to measure our core values and changes. As a consumer representative with Mental Health ACT, we expect and demand outcome measurements from the Health System. A project like this shows that, as a Network, we need to develop the capacity to form outcome measurements for and from our own sector.

Although the relationships discussed in this paper are presented as a new model, this is something that the Network has been working towards, and doing, for many years. Our work in the mental health sector forces us to look at how to get along with the health system so that our voices are listened to and we are effective. As much as we are working within this model, its success relies on all sectors in mental health embracing it in equal partnerships. As I learned when I found the Network, being diplomatic can lead to better outcomes. Perhaps, though, this report can add to the dialogue about ways forward in the mental health sector.

This report will be available on the Network's website for anyone who wants to know more about what we as a Network do and what we are about. We also think this report could be used to send to people or other organisations in the mental health sector that would be interested in, or could spark an interest in, the Network and mental health advocacy.

Executive Summary

Project Overview

This report presents the findings of a research project conducted during January – June 2009. The project's primary objective was to provide analysis of the ACT Mental Health Consumer Network's (ACTMHCN, the Network) current communications of the organisation's strategies to achieve its key goals. A subsidiary objective of the project was to seek feedback from ACTMHCN experts on a way of describing the goals and aspirations of mental health advocacy organisations that is new in the academic literature on reducing stigma.

Approach and methods

Two methodologies were drawn on to explore the objectives. First, an analysis of the content of six strategic communication documents was conducted to identify the way in which the organisation's goals, actions and values were presented to the membership and external parties. This analysis was followed with a series of five interviews with selected ACTMHCN members and staff. The interviews were designed to provide additional insight into views about what the ACTMHCN was working to achieve and what change in the community they aspired to. The interviewees were also asked to consider a specific way of describing the goals and aspirations of mental health advocacy (shown in Figure 1).



Figure 1. Image presented to interviewees as a proposed set of relations for the mental health sector

Key findings

The analysis of document content showed that the following goals, actions and values were consistently and frequently mentioned in the documents: doing and supporting

representational work; improving mental health services; advocating social justice principles; being informed about developments in mental health; communicating the consumer's view; and collaborating with other agencies. The goals, actions and values that received the least coverage in ACTMHCN documents related to: consumers' reintegration in the community; unity among consumers; upholding the rights and reducing discrimination of people with mental illness; empowering consumers; and promoting respect. Although these issues did not receive as much coverage in the documents, interviewees consistently raised them as important issues.

A second key finding from the research project was the importance of *ordinary* consumers being recognised for their everyday achievements. Interviewees described this as people with mental illness needing to be "artful" in the world and "the ability to contribute things otherwise fairly ordinary... that can be seen as quite an achievement in itself". The interviewees clearly saw this as an important message about the contributions that people with mental illness can make.

A third key finding, relating to the subsidiary objective of the research project, was that interviewees saw potential in reducing stigma and influencing mental health reform by being part of a revised set of relations which might help re-define mental health consumers, health providers and members of the community as working together with a shared vision.

Recommendations

RECOMMENDATION ONE: The ACTMHCN considers the current balance and mix of themes in strategic communication documents and considers whether a stronger emphasis on the empowerment of mental health consumers, promoting unity among consumers and promoting respect in the community is desirable for key communication documents.

It is not surprising that representation, improving mental health services and social justice principles receive significant attention in the documents of a systemic mental health advocacy organisation such as the ACTMHCN. It is surprising, however, that empowering mental health consumers, reducing discrimination against people with mental illness and promoting community respect and unity among consumers received considerably less coverage, particularly given that these issues were raised as being important in the interviews. It is recommended that the ACTMHCN considers whether

these concerns should be more strongly communicated in strategic communication documents to portray a more complete picture of the Network's approach.

RECOMMENDATION TWO: The ACTMHCN considers using the theme of *ordinary heroes* in key communication documents to consumers and the public.

In line with suggestions from interviewees, there is the potential to boost membership of the ACTMHCN by boosting the number of people in the community that identify with the organisation. One way to achieve this is to directly describe Network representatives and members as everyday consumers who contribute to positive change within a supportive environment because they are committed to seeing better conditions. In other words, members of the ACTMHCN are ordinary heroes, like those in the wider community, who are achieving gains and making important contributions. Public materials, such as the existing website and brochure, are ideal avenues to present this view.

RECOMMENDATION THREE: The ACTMHCN further considers the descriptive model for reducing stigma and influencing reform.

Interviews with members indicated that the descriptive model in which people with mental illness, health providers and community members work together to reduce stigma and influence reform may have considerable potential. It is recommended the ACTMHCN further considers the applicability of this model for their own work and, if it is deemed fruitful, identify possible steps to facilitate commitment to this approach within the mental health sector. These steps should be guided by the key aspects of the approach identified by interviewees as necessary for it to work (see findings outlined in Required Key Aspects for the Model as Identified by Members in this report).

Context and Overview of Research Project

Many people who experience mental health issues face the significant problem of stigma, a process of being labelled, viewed negatively, excluded and having services and rights withdrawn or made unavailable (Link & Phelan, 2001). Many people with severe mental illness have described the stigma they experience to be as distressing as the symptoms themselves (Hocking, 2003). To the extent that this stigma exists in the mental health system itself, it presents significant barriers to consumer participation in the evaluation and development of mental health policy, services and practices (see Happell & Roper, 2006).

Mental health advocates work to address some of these barriers, which are seen to maintain inadequate services and policies. The World Health Organisation (2003, p9) states, “mental health advocacy includes a variety of different actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations”. Mental health advocacy groups, such as the ACT Mental Health Consumer Network (ACTMHCN), work to change the necessary structures relating to the way people with mental illness are cared for and treated by the community and services as well as the *processes* by which society conceptualises mental illness, provides health services and develops mental health policy. The ACTMHCN, then, is a systemic advocacy group and this reflects its members’ view of these systems, and the processes that underpin them, as fluid and changeable rather than only dependent on the framework which maintains them.

Reducing the stigma of mental illness and the barriers it presents would result in more opportunities for people experiencing mental health issues, services that are more responsive to consumers’ needs (thus producing better outcomes) and a more inclusive community. Clearly, then, this stigma must be targeted. A research project was conducted to investigate how the approach and work of the ACTMHCN, a systemic advocacy organisation, influences positive change and addresses the stigma of mental illness. This report presents the key findings of the research project, and a discussion of possible steps forward, according to:

- the primary research objective to provide an analysis of the ACTMHCN’s communications about the organisation’s goals and strategies; and

- the subsidiary objective to seek feedback from the ACTMHCN on a way of describing how organisations like the Network aim to influence mental health reform and reduce stigma that is new in the academic literature.

It is important to emphasise that the expertise of the project team is in research at the interface of social and clinical psychology and in particular in relation to issues of preventing and reducing stigma about mental illness. Although the project involves an analysis of the content of strategic communication documents using appropriate psychological research techniques, and we provide that analysis here on a pro bono basis, the project team is not comprised of marketing and communication professionals. Specific advice on communications strategies should be sourced from professionals in that area.

Methodologies of Research Project

To identify the ACTMHCN's goals, activities and values, and determine the relative coverage of each, the following core documents and communications from 2007-2008 were examined (see Appendix A for an outline of the coding process):

- *The Constitution* (2007)
- *Annual Report* (2007-2008)
- *Network Workplan* (2007)
- *The ACTMHCN Newsletter* (Issue 1, 2008)
- *The ACTMHCN Brochure* (n.d¹)
- *About Us* website document (n.d¹).

In addition, interviews were conducted with five members of the governing committee and staff, each of whom had been with the ACTMHCN for at least two years. Interviews were guided around the following topics for discussion:

- interviewee's perspective of what the ACTMHCN was working to achieve
- the type of community the ACTMHCN and interviewees were aspiring to
- feedback on a proposed set of relationships for positive change (Gee, Khalaf & McGarty, 2007), represented in visual form. This discussion included possible improvements as a result of the approach, key aspects for the approach to work, barriers to the approach, current barriers faced by mental health consumers, and the potential applicability of the approach for the ACTMHCN.

¹ Accessed online January 2009 from <http://www.actmhc.org.au>

The ACTMHCN's Goals, Strategies and Values: Findings from a Content Analysis of the Documents and Interviews with Members

Overall, a number of themes came out very strongly across the ACTMHCN's goals, actions and values. Material from documents and interviews indicated the ACTMHCN was primarily about: representation and providing training and support for representatives; improving mental health services; social justice principles; being informed about developments in mental health; communicating the consumer's view; and collaborating with other agencies.

The ACTMHCN goals, actions and values that received the least coverage in the documents were about: consumers' reintegration and inclusion into supportive communities; unity among consumers; upholding the rights and reducing discrimination of people with mental illness; empowering consumers; and promoting respect. However, these were consistently raised by interviewees as important issues.

The goals, actions and values identified from the documents and interviews will now be presented in more detail (see Appendix B for tables presenting the results of the document analysis, specifically definitions and examples of each goal, activity and value and the number of times that each is referred to in the documents).

Identifying the ACTMHCN's Goals

Analysis of the documents revealed 15 goals for the ACTMHCN. The goal to provide representation for consumers was referred to most often, followed by the goals to improve mental health services and communicate and work collaboratively with others. Also fairly strong in the documents was the goal to build a strong organisation to ensure sustainability.

On the other end of the count, the goal to facilitate reintegration and inclusive communities for people with mental illness was referred to least often, followed by the goals to uphold the rights and overcome discrimination of people with mental illness, represent unity among consumers, and empower people with mental illness.

Note that the number of times each goal is referred to in the documents should not be interpreted as a measure of their comparative importance for the ACTMHCN. We cannot

conclude, for example, that the goal of providing representation was four times more important to the Network than upholding the rights of consumers. A more accurate conclusion is that the two goals are very closely linked and, further, upholding the rights of mental health consumers probably drives the objective to provide representation. Nevertheless, the amount of written content devoted to each goal provides a good indication of the messages conveyed to the public and relevant constituents and stakeholders.

Goals for the ACTMHCN as identified by interviewees were to:

- act in the interests of mental health consumers
- bring consumers into all levels of service design, development, delivery and evaluation for mental health care in the A.C.T.
- express the consumer voice
- influence committees to include consumers
- provide quality information about developments in the mental health sector (including research) and to inform members and the community of events
- put a consumer perspective to the mental health system
- raise concerns that are important for mental health consumers.

Broader goals identified by interviewees for the ACTMHCN were consistent with the goals receiving the least attention in the documents. Interviewees described the Network as working towards achieving:

- a focus on the promotion of mental health
- a place where mental health consumers can attend without negative judgment they may otherwise find in the community
- a voice for what does and does not work for consumers
- change in the current power relationship between consumers and professionals in the mental health service to one where consumers are included in a collaborative effort
- change in the systemic issues that prevent consumer-driven best outcomes
- health and mental health services that meet everybody's needs and result in the best possible outcome for the consumer of that service (particularly for people with mental health issues)
- health services where the 'best outcome' is defined by what consumers of those services deem as the best outcomes

- less stigma and discrimination and more compassion and understanding for people who have experienced mental health issues among committees and the community, which arises through hearing a consumer perspective
- members who are kept informed of developments in mental health to assist in individuals making informed decisions that are right for them (for example, decisions about treatment and consumer participation)
- representation for a broad range of consumers in the community, including the variety of ethnic communities and the variety of those with mental health problems, from “psychiatric survivors” to “normal urban neurotics”.

Identifying the ACTMHCN’s Actions

Analysis of the documents revealed eight types of activities for the ACTMHCN. Activities relating to representation, advocacy and lobbying received the largest number of references in the documents, with more than double that of providing training, knowledge and support for representatives and members (such as media training, consumer advocacy training, attending conferences and the opportunity for debriefing). This is entirely consistent with the ACTMHCN’s goal to provide representation for consumers, which also received the highest number of references (discussed above).

Also among those activities receiving the largest number of references were collaborating and networking with other agencies (by, for example, sending invites to become members of the Network, jointly hosting activities) and providing information and resources to the public and as support for members (for example, by holding Forums, updating the website and distributing the *Newsletter*).

Strategies to boost membership of the ACTMHCN received fewest references and information was not available as to whether these planned activities, such as holding fun runs, short story competitions and distributing flyers widely were completed (*Network Workplan*).

The Constitution was the only document that contained no references to any type of activity aside from committee meetings held as standard governance practice. This document was primarily about outlining the specific processes and expectations for members and committee members of the Network. Surprisingly, this document did not specify the roles, expectations and other processes for representatives of the Network. It is understood the Network is currently working on such a document.

Note also that, unlike the other documents, *About Us* contained reference to only one type of activity (representation and advocacy), indicating the focus of this document is to communicate the goals and values of the Network to the public.

Interviewees also described activities by members of the ACTMHCN, such as:

- attending conferences (including conferences with people from multiple disciplines)
- distributing the newsletter and using email lists to share information about developments in mental health
- including consumers in the training for mental health clinicians and community workers
- the Network's representation work on numerous committees
- making statements to the media
- networking with others.

Identifying the ACTMHCN's Values

While the goals and activities provided a clear picture of what the organisation was aiming for and doing, identifying the values of the ACTMHCN gave a good indication of the principles that guided that direction and activity.

Analysis of the documents revealed 11 values for the ACTMHCN. Content reflecting social justice principles occurred most frequently, which housed a number of sub-components such as equitable access to services and the importance of services and legislation based on participation and human rights. These principles strongly reflect the ACTMHCN's goals to represent the consumer view, promote participation and influence policies and services (described above).

The principles of social justice were referred to twice as often as the next highest value (being informed). Valuing consumer knowledge and experience also had significant presence in the texts, with many references to presenting the unique consumer perspective and expressing the consumer voice.

Receiving the lowest number of references in the documents were valuing (and developing) members' skills and strengths and characterising communities and relations based on respect. The value of respect was uniquely contained in the *About Us* document,

which was indicated as the desired basis for relations between consumers and others in the community. This was the only value contained in the *About Us* document, thus showing that in one of the key communication documents to the public, the ACTMHCN is presenting a clear message that respectful relations is a strong basis for what they do and what they are about.

It is also important to note that, although distinguishable, some values identified in this analysis are nevertheless very strongly related. Consider, for example, representation, which reflects the principles of social justice (by, for example, recognising individuals' rights, providing a voice for consumers and promoting consumer participation). Additionally, though, representation is about valuing consumers' experiences and knowledge, facilitating empowerment, showing pride and promoting a respectful environment (all of which were also among the identified values). This example shows that, although content was coded onto the one value it explicitly reflected, one activity can reflect many values. Thus, there is evidence in the ACTMHCN's documents that the organisation's values run very strongly through its activities, goals and overall approach.

Values for the ACTMHCN that arose in interviews with members and staff were:

- autonomy for consumers in being able to make informed decisions (for example, about treatments or participation)
- being representative of the community of mental health consumers in the A.C.T.
- consumer perspectives
- diversity of knowledge and ideas
- members' contributions to the newsletter, such as poetry, art or written pieces
- mental health consumers and members of the Network remaining informed, educated and up-to-date about developments and events in mental health
- new conceptions of knowledge
- the intelligence of consumers.

Barriers Faced by Mental Health Consumers and Members of the ACTMHCN

The documents contained two types of barriers faced by mental health consumers and the ACTMHCN. There were nine references (all from the *Annual Report*) to difficulties faced by the ACTMHCN from those outside the organisation. Two of these referred to stigma (for example, from medical professionals), while others referred to funding restrictions in the system or less defined causes (for example, “[serving the Network] has felt like

running a race, and yet in some areas of the mental health field, it feels as though nothing has changed”, p3).

There were a further eight references in the *Annual Report* to difficulties faced within the organisation itself, such as staffing changes, fatigue among representatives and stressful workloads of committee members.

Interviewees raised the following barriers faced by mental health consumers and members of the ACTMHCN:

- a narrow preference of communication style, which can make it difficult for some consumers to be representatives (and be heard)
- committees that do not provide relevant material to representatives in advance of meetings
- finding enough people to do advocacy and representative work can be challenging and this is made more difficult given the demands, skills required and current barriers to being a representative
- negative judgements in the health care system itself as well as the general community
- services and service providers that expect consumers to be grateful for the service offered, even though it does not meet consumers’ needs
- the current distinction between people as being either “ordered” or “disordered”, with a clear emphasis on the ideas of “ordered” people being more highly valued
- the harm model of understanding, where consumers are seen as dangerous, effects how people in representative committees respond (for example, by not engaging fully in discussing ideas due to fear of “upsetting” consumers)
- the biomedical model of understanding who consumers are that
 - does not allow for understanding from a consumer perspective,
 - focuses on disease or deficits rather than seeing someone with mental illness as a whole person (with desires, ambitions and goals in the world),
 - is particularly strong among psychiatrists and clinicians,
 - is taken up by members of the general community,
 - promotes patriarchal attitudes towards people with mental illness and
 - results in a “one-size-fits-all” approach to services.

The ACTMHCN's Aspirations for the Community

One aspiration for the community was uniquely contained in the ACTMHCN's *About Us* website document. This aspiration described a “respectful and accepting system that involves Consumers, Carers and Professionals listening and respecting one another in an active healthy relationship”.

Interviewees described the following aspirations for the type of community they would like to see develop:

- a community based on the values of “creativity, innovation and excitement” rather than the exclusion of difference or perceived “deformity”
- a community that provides options and flexibility in meeting the needs of people with mental illness
- a community where consumers are always listened to, particularly by health professionals, and where consumers have a say in their own treatment options (such as the type of medication they have)
- a community where consumers are “treated like people with full rights”
- a united and more compassionate community where the myths about people with mental illness are dispelled and having a mental illness is no longer seen as such a negative and debilitating thing
- an approach to system and community reform that allows for a number of different approaches to address problems with the current situation (including valuing “ordered” and “disordered” thinking equally)
- an inclusive community that values consumers' needs equally to the needs of other people in the community
- consumers are recognised for the positive contribution they can make as much as other community members
- consumers involved in representative work being recognised for their intelligence, experience and knowledge.

Recognising the achievements of ordinary consumers (or *ordinary heroes*)

Interviewees reported the desire for consumers to be recognised for the positive contribution they can make to the community. This was described by one interviewee as an aspiration that would see the recognition of the creativity and “artfulness” required by many consumers to live in the world. Another interviewee stated, “the ability to contribute things otherwise fairly ordinary... that can be seen as quite an achievement in itself” for people managing mental illness.

ACTMHCN Members' Views on a Model that Defines Relations Between the Key Players in Mental Health to Influence Reform and Reduce Stigma

Interviews provided the opportunity for ACTMHCN members and staff to put forward their views and provide feedback of a proposed model for influencing mental health reform and reducing stigma. The proposed model is a new offering to the psychological research literature on reducing stigma. For this project, input was sought from those working in the mental health advocacy sector on their views about the relevance, applicability and potential of the set of relations defined by the model.

In presenting these findings, interpretation and explanation of the proposed model will be described through the words of the ACTMHCN members and staff interviewed. A more detailed account and theoretical basis of the model will be provided in the General Discussion of this report.

Members' Interpretations of the Proposed Descriptive Model

Interviewees were asked to consider a set of relationships that looked like that presented in Figure 2, in advancing the cause to realise the aspirations for the community they described (see above).



Figure 2. Image presented to interviewees as a proposed set of relations for realising the ACTMHCN's aspirations

Upon viewing the image, interviewees first noticed the interlocking area of the image and referred to this in suggesting that the image represents:

- a similar approach between groups

- common aims or shared ambition, reflecting a common interest for particular outcomes to be achieved
- common experience
- common ground
- connectedness
- interaction between groups or the groups working together
- interlinking that represents that “we’re all in this together”
- less distinction between groups
- overlapping groups
- tightly interlocking groups.

Members’ Views about the Potential of the Descriptive Model

All interviewees indicated the image was positive or that it would bring improvements to the current situation, such as:

- a more harmonious community generally
- a sense of belonging, resulting in less self harm and suicide
- all opinions and input being balanced and taken into account by each individual and the community as a whole
- better communication and more dialogue between groups
- better interaction between groups leading to more productive advocacy outcomes (particularly with advocates and health professionals working together)
- bringing cultural change quicker
- bringing the groups closer together and providing the opportunity for interaction at social events in the mental health sector
- more awareness in the community about the true nature of mental illness (for example, that it’s not necessarily extremely disabling), leading to changes in contact with community members (including bus drivers, the police, and in supermarkets)
- more knowledge and understanding among health professionals about the approach and work of consumers, particularly the ACTMHCN, due to increased interaction
- recognition that mental illness is something that can be talked about as a community
- sharing experiences, common ground and reducing the gaps in experiences between the groups

- the opportunity for each group to learn about the others' perspectives, resulting in greater understanding and empathy.

Required Key Aspects for the Model as Identified by Members

Interviewees identified the following key aspects for the approach presented in the image to work:

- all members in the groups share and recognise a common desire for improvement with the view of moving forward
- consumers listening to and understanding the pressures and approaches of health professionals
- each group being willing to admit when mistakes were made and when things could have been done better
- each group is seen as having a contribution to make
- education of the roles and expectations of each of the groups
- education, recognition and deep listening to the consumer perspective, particularly
 - about the effects of mental illness so that individuals experiencing mental health issues are seen “as human beings”,
 - in coming to understand the consumer as a whole person and not just as a condition,
 - to move away from the medical model as the sole way of understanding people with mental illness and
 - to overcome the negative attitudes of professionals that develop based on particular work experiences (for example, those working in crisis come to see people with mental illness as dangerous and their approach reinforces the harm model of legislation and service delivery)
- effort on the part of those involved to get over the divide and build up the intersections
- ensure that consumers, and those in representative work, are resourced sufficiently to be able to continue their work and stand strong
- having some degree of movement in and out of the formation so that each group continues to be strong and effective in completing its own work and is not worn down by the process of interacting
- increase the qualifications of health providers offering services
- leadership from higher levels to clearly define and communicate the intended direction where we are going and to guide what needs to be done at ground level

- realisation that the distinction between the groups is not necessarily as clear as currently believed, for example by
 - consumers having a more active (self-directed) role in their own health care and in doing so, participating in more activities traditionally reserved for health professionals,
 - having more people with mental illness employed as health professionals,
 - realising that people with mental health issues are not necessarily that different from others and
 - seeing the general community as including those who live with mental illness by pointing out, for example, that anyone in the general community can be affected by mental illness and that people with mental illness can “transition” into the wider community group with the right support
- relations between groups should be based around compassion and understanding
- stop the politics between different health professionals
- that diversity remains within each group
- that the groups are open about their own agendas
- the more people that become part of the approach the more effective it will be
- willingness for people to let go of their own ideas at times.

Two interviewees put forward alternative models to the one proposed. The principles of these are reflected in the points above, particularly that there should be more recognition of the overlap (i.e., less distinction) between the groups. One interviewee emphasised that having some movement away from the interaction is vital at times to buffer against consumers being worn down by the interaction process. It was suggested that constantly being in the interaction is debilitating for consumers due to the presence of stigma and the interaction being underpinned by the “conventions of everyday conversations ... [so that] the only way to disrupt that is to separate out of it for a while”. This interviewee also suggested that having consumers and health providers “opening up to each other more” (i.e., developing a stronger relationship) would then pull the community closer through that movement.

The second interviewee proposed a model that further emphasised the similarity between health providers, community members and consumers. This interviewee described the relationship between group members reflecting an idealisation that did not distinguish between the three groups, stating “people would see themselves as occupying those roles equally ... there wouldn’t be the need to especially insist on expressing the consumer

voice because everyone else would be to some extent expressing the consumer voice”. In this arrangement, it was said the consumer contribution would be recognised and presented automatically.

Members’ Suggestions for the Roles of Community Members

As much of the discussion of the proposed model was around the relationship between consumers and health providers, interviewees were also asked specifically about the role of community members in reform. Overall, interviewees agreed there could be an important role for community members, suggesting that:

- community members could be involved in committees, where they would learn the consumer perspective for systemic advocacy and understand the work that is involved
- having the broader community involved in some level shows that community members “have a stake in [change]” because of the relevance of community issues raised by consumers (such as homelessness and employment issues)
- influencing a considerable portion of the community is important for other community members to come on board
- it would be important to have community members understand the perspective of consumers and have more education about mental illness.

Barriers to the Proposed Approach

Two interviewees stated there were no limitations to the proposed approach if it was put into practice and had the key aspects (listed above). Interviewees raised two barriers to achieving the proposed approach:

- getting health providers to commit to this approach could be difficult because the attitudes of some would need to change significantly
- the possibility that health professionals would prefer to keep the current arrangement to keep their “prestige” and promote themselves as being an “elite group with exclusive knowledge of the situation”.

Members’ Views about Possible Applications of the Model for the Network

Potential applicability of the proposed approach to the ACTMHCN was discussed with three interviewees (note that this was not discussed with the other two interviewees due to timing restrictions). Of those who discussed this topic, two interviewees stated that this approach is something that the ACTMHCN should be striving for. Interviewees suggested two possible applications of the model for the ACTMHCN:

- attempting to understand better the perspective of health professionals could result in less defensiveness on their part, which could then allow representatives to potentially identify better where the problem associated with a bad outcome may have stemmed from. As one interviewee described, working this way with health professionals “wouldn’t stop us getting the outcomes that we ultimately seek, might even be a better way of achieving those, but once you get the health professionals defensive and a bit anxious about outcomes, then they can sort of close down and withdraw a bit whereas the only chance to get things done is by having some kind of dialogue and interaction”
- the ACTMHCN’s current work was involved in all three areas outlined by the model.

General Discussion and Looking Forward

The findings of this research project show that the ACTMHCN has clearly defined its goals in key organisational and public documents. The findings show that the actions and values of the ACTMHCN are also readily identifiable from the documents.

Overall, responses from interviewees were highly consistent with the themes that emerged from the document analysis. Interviewees, however, conveyed a stronger feel for the type of community that the ACTMHCN was trying to achieve than described in the documents (see Recommendation One in the Executive Summary of this report). Interviewees’ responses were also consistent with each other.

One additional issue that was raised by interviewees was the desired recognition of mental health consumers achieving “ordinary” things and needing to be “artful” and resourceful in their everyday lives. Indeed, anti-stigma campaigns often present in the media the *exceptional* people with mental illness: the actors, the academics, the comedians and the film makers, who also happen to have a mental illness. There is much less heard about other people in the community living with mental illness that are also making important contributions to their community. Members of the ACTMHCN are themselves some of these *ordinary heroes*, as they are ordinary members of the community who are achieving significant gains in mental health advocacy whilst themselves being consumers of mental health services. It is true that advocates are passionate, driven, committed, professional and skilled, however these are values that are also developed by being part of a mental health advocacy group. Previous research (e.g.,

Gee, Khalaf & McGarty, 2007) has shown that people are much more likely to get involved in something if they see the people already doing it as similar to themselves. The important aspect of this is that similarity is not based on being in the same category (like having a mental illness), it is based on other dimensions such as sharing a passion (or opinion) about seeing a better world for people with mental illness (see also McGarty, Bliuc, Thomas & Bongiorno, 2009). Portraying this similarity of members of the ACTMHCN with members of the wider community may help to boost membership of the Network (see Recommendation Two in the Executive Summary of this report).

Through the combined written and interview materials, the ACTMHCN could easily identify numerous barriers faced by people with mental illness and consumer representatives engaging in mental health reform. Despite these significant difficulties, interviewees expressed a great deal of positivity and hope for significant positive change for the future. In doing so, members recognised the hard work of consumer advocates and members of the Network in advances in mental health reform achieved thus far.

Although much discussion (and some written content), particularly about those barriers, focussed on unhelpful attitudes and actions of some health providers, members also readily identified and described how health providers can be instrumental in bringing about positive change. Indeed, although members felt a sense of *us* (consumers) *versus them* (service providers, policy makers) in their representative work, time and again the discussion reflected a desire to work better with health providers by helping them come to understand consumers and consumer advocates, rather than wanting to instil (or continue) a divide. As one interviewee eloquently described, “I think [with] a large part of what the Network does, we’re trying to help health professionals do *what they want to do* better, by filling in the gaps of knowledge and empathy and understanding” (emphasis added).

The model presented to interviewees in this project, then, as members so readily interpreted, perhaps offers a fitting framework for defining relations in the mental health sector and direction for the ACTMHCN (see Recommendation Three in the Executive Summary of this report). This model, termed a cooperative community for positive change (Gee, Khalaf & McGarty, 2007) is new to the psychological literature on reducing stigma and will now be described in more detail.

According to the research literature, one way to reduce discrimination and prejudice is to create, instead of different groups, one big group to which everyone belongs (e.g.,

Gaertner et al., 1993). For example, rather than people identifying as being a mental health consumer, a service provider or a community member, these distinctions are ignored in favour of a larger basis of the grouping, such as everyone involved in the mental health sector.

The descriptive model represented by the three-ringed image (see also Figure 3) is somewhat similar to this principle, in that it attempts to create common ground where those involved can come together on equal footing. However, it differs to the one-group approach in two very important ways.

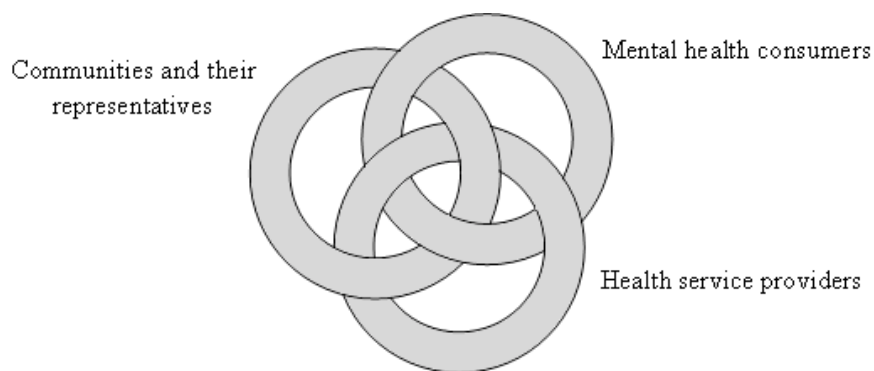


Figure 3. A cooperative community for positive change

The first point of difference is that the proposed model, as well as providing common ground, recognises that the different groups of people involved have different expertise. That is, it is *important* for consumer representatives of the ACTMHCN to identify as mental health consumers (or as psychiatric survivors) because doing so denotes their *unique, lived expertise*. It is through this identity that we can truly have the input from the perspective of people who have received (and in more consumer-driven services, shaped) those services. In other words, for members of the ACTMHCN, being a consumer of mental health services *means* something, as reflected in their statement that the Network “is run by consumers for consumers” (*About Us*).

Equally, it is important to recognise who the health providers are, and the particular expertise that comes from them, as having providers on board will be important in helping to produce change from within the service. Just as it is important to define who are community members, as having these on board will be important to make changes at the

community level and to influence decision making and policy development (after all, those working in government are representatives of the community).

Thus, having the input of those who identify as mental health consumers is vital to move towards a service system that is better able to meet the needs of people with a mental illness (needs which have been voiced by consumer representatives) and to see a service system that makes a greater positive difference for those experiencing a mental health issue. As dedicated and hardworking as consumer representatives are, though, the current set of power relations means that consumers can not do it all themselves; they also need to be able to influence the people who can make (and enforce) the changes that consumers advocate.

The second important point about the proposed model, then, is the way that it defines the relationships between the groups involved. Note that the positioning of the rings is not meant to portray any degree of power imbalance between the groups. The more important aspects of their position is the way they interlink and their proximity to each other. Historically though, and even currently as mental health consumers and members of the ACTMHCN well know, the relationship between the groups represented by the model has indeed been characterised by a power imbalance such that the involvement of consumers in the mental health sector has been largely in an attempt to define them purely in a passive capacity. As such, mental health consumers are involved in services that need to be done *to* them (and for which they should be grateful). The ACTMHCN works hard to shift that balance and have consumers take on a much more active role in service decisions, delivery and evaluation, thus reflecting a more equal balance of power. From discussions with interviewees for this project, it seems that relationships in this area are shifting to be more positive. As one interviewee said, similar to the story of Christmas 1914 in World War I, “we [consumers and health providers] are putting our arms down and having a game of soccer in between the trenches”. Perhaps, then, this provides a good opportunity to pause and reflect on the type of relations we *do* want. One strategy for continuing to move forward, which we have been suggesting in this report, is to work to create a set of relations where the groups involved are not fighting *against* each other to be heard and understood (or to shut the other down), but one where the groups are fighting *for* positive change together.

From the comments of interviewees presented in this report, such a direction does not seem to be a foreign or unwanted movement. Interestingly, the ACTMHCN’s own *About*

Us document on the organisation's website refers to a similar aspiration, where "we promote a respectful and accepting system that involves Consumers, Carers and Professionals listening and respecting one another in an active healthy relationship". Perhaps such an approach could overcome many of the barriers identified by interviewees that people with mental illness and consumer advocates face.

On a final note, in talking with the ACTMHCN advocates, it has become clear that influencing change is a long and bumpy road where the light at the end of the tunnel can get intermittently closer and further away. Hopefully, this report is a small contribution that could make that light a little larger and within arm's length for mental health consumers, service providers, government members and community members alike.

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Acknowledgements

by Alison Gee

I owe much thanks to the ACTMHCN. A sincere thank you goes to all interviewees for sharing your views with me for this project. Your insightful comments on a model you only had a few seconds to grasp were much appreciated and help me to better understand the work and vision of mental health advocates. I believe the richness in this analysis comes from your comments and I sincerely hope that the richness of ideas from those with experience with mental illness is soon given the genuine recognition it deserves in the processes of the mental health sector. I believe it will thanks to representatives like those belonging to the Network.

I would also like to give a special mention to Michael Firestone, David Lovegrove, Bradley Foxlewin, Jane Williams, committee members and other members and staff for their excellent feedback on earlier versions of this report and enthusiastic support of this project. It has been a pleasure to work with you.

Having shared so many of your thoughts with me, perhaps it is my turn. I understand that advocacy work is a long and sometimes difficult and frustrating process, but I believe there is that commonality where we look forward to a world that more strongly encourages consumer participation and has the needs of consumers in mind. I strongly share a vision for a world based on respect and inclusion and I eagerly anticipate such a world.

Appendix A: An Outline of the Coding Process for Analysis of Documents

This appendix provides a description of how document content was coded to identify the reported goals, actions and values.

General Coding Strategy

Coding of document content was driven by the pre-defined categories of goals, activities and values. Content could be words, sentences or paragraphs and some initial coding grouped similar ideas or sentiments together. As this initial coding progressed, the common themes became more clear and specific goals, activities and values could then be identified. Once this coding structure had emerged, the documents were analysed a second time to ensure this structure fit with the content of the documents and to ensure consistency in the coding approach.

Goals or Activities and Values

Content was coded as either a goal or an activity and was coded onto only one specific goal or activity within those categories. Values (also with content coded onto only one) could emerge from material that had also been coded as a goal or an activity. Consider the following examples:

- “Goal 1 – Build and utilise consumer knowledge” (*Network Workplan*) was coded as a goal to develop consumer knowledge (that is, coded as only one goal) **and** coded as a value to recognise consumer knowledge and experience (also only one value)
- “Goal 2 – Express the consumer voice” (*Network Workplan*) was coded as material reflecting a goal to provide a voice for consumers **as well as** the value of recognising consumer knowledge and experience.

As a result of this double-coding, the counted number of references could add up to more than 100% of coded material.

Goals

The goals that emerged from the document analysis were identified in statements that reflected aims for the ACTMHCN, or what the organisation wanted to achieve. These were variously referred to in the documents as aims, goals, objectives, vision or strategies.

Activities

The ACTMHCN's activities identified from the documents included those that were:

- future oriented and presented as planned activities in the documents (for example, as in the *Workplan*)
- currently underway, in which case the documents provided updates on these (such as in *Newsletter*)
- completed (such as those in the *Annual Report*).

Values

Values were most often identified in content that described goals and activities, although were also present in narratives and other communications (such as quotes from advocates in the *Brochure* and reports in the *Newsletter*).

Appendix B: Tables Presenting Results of the Document Analysis

This Appendix provides the results of the content analysis. The following Tables are included:

- Table 1: Definitions and Examples of the ACTMHCN's Goals Identified in Documents
- Table 2: Number of Times Each Goal is Referred to in the ACTMHCN Documents
- Table 3: Definitions and Examples of the ACTMHCN's Activities in Documents
- Table 4: Number of Times Each Activity is Referred to in the ACTMHCN Documents
- Table 5: Definitions and Examples of the ACTMHCN's Values Identified in Documents
- Table 6: Number of Times Each Value is Referred to in the ACTMHCN Documents

Table 1. Definitions and Examples of the ACTMHCN's Goals Identified in Documents

Definition of Network goal (name of goal in bold):	Examples from documents
1 Be proactive and take action in the Network's approach	"To provide proactive systemic advocacy" (<i>Annual Report</i>); "Acting in the interests of mental health consumers" (<i>Brochure</i>).
2 Collaborate and communicate effectively with others (e.g., non-government, government and community agencies) and facilitate effective communication between consumers, professionals and carers	"... make our interests known to the broader community" (brochure); "Communicate effectively with government and non government organisations and the community" (<i>Workplan</i>); "Work collaboratively with other organisations and mental health consumers" (<i>Annual Report</i>).
3 Draw on and develop the use of consumer knowledge	"Build and utilise consumer knowledge" (<i>Workplan</i> ; <i>Newsletter</i>); "... valuing [consumers'] experiences of the mental health system in the A.C.T." (<i>About Us</i>).
4 Develop consumer research and consumer policy	"Develop consumer research and policy capacity" (<i>Workplan</i>); "Participating in and assisting with research programs" (<i>About Us</i>).
5 Empower consumers	"Empower consumers to utilise all means to achieve and maintain better mental health" (<i>Constitution</i>); "... To empower consumers" (<i>About Us</i>).
6 To educate and inform members, representatives and others and to facilitate learning	"Grow and support ACTMHCN as a learning organisation" (<i>Workplan</i> ; <i>Newsletter</i>); "Increase mental health literacy amongst consumers and service providers" (<i>About Us</i>).
7 Improve mental health services, policies and practices	"... to create a system that works better than this one" (Quote from representative, <i>Brochure</i>); "Improving health and community services" (<i>Newsletter</i> ; <i>Workplan</i>).
8 Influence change in mental health policy and services	"... influence decision making" (<i>Brochure</i>); "Changing mental health services" (<i>Workplan</i> ; <i>Annual Report</i>).
9 Build an established and sustainable organisation	"Build and sustain ACTMHCN's organisational capacity" (<i>Workplan</i> ; <i>Newsletter</i>); "To govern the ACTMHCN in a responsible and sustainable way" (<i>Annual Report</i>).
10 Build consumer participation in policy and services review and decision making	"Participating in ... health and community services" (<i>Newsletter</i> ; <i>Workplan</i> ; <i>Annual Report</i>); "... I let them know that they need to include us in decisions" (quote from representative, <i>Brochure</i>).
11 Facilitate reintegration and inclusive communities for people with mental illness	"To create and build a supportive environment within the organisation and outside" (<i>Annual Report</i>); "Working towards reintegration into quality life in our society" (<i>About Us</i>).

12	Uphold rights of consumers and overcome discrimination	“Disseminate information and utilize other strategies aimed at enhancing recognition of rights and overcoming discrimination” (<i>Constitution</i>); “For many of us, there is a silent determination not to let the lack of understanding of others stop us” (quote from representative, <i>Brochure</i>).
13	Consumers representing unity	“I want to make links between our lives and to find ways in which we can take action together” (quote from representative, <i>Brochure</i>).
14	Provide representation for consumer issues	“... the Network continues to represent a broad range of views and personal experience about the mental health system” (<i>Brochure</i>).
15	Provide a voice for consumer issues	“...remind people that, despite having a mental disorder, we actually do need a voice, and can often speak not just for ourselves, but also for the members of our community that don't have a voice” (Chair's Report, <i>Annual Report</i>)

Table 2. Number of Times Each Goal is Referred to in the ACTMHCN Documents

Goal	Document						Total References
	<i>Consti- tution</i>	<i>Annual Report</i>	<i>Workplan</i>	<i>Brochure</i>	<i>Newsletter</i>	<i>About Us</i>	
1 Proactive	0	1	1	2	2	0	6 (3)
2 Collaborate	3	2	5	1	0	1	12
3 Consumer knowledge	0	0	2	0	1	1	4
4 Research and policy	0	0	4	0	1	1	6
5 Empower	1	1	0	0	0	1	3
6 Educate	0	0	4	1	1	4	10
7 Improve	3	1	1	2	3	2	12
8 Influence	0	2	1	3	2	0	8
9 Organisation	0	1	5	0	2	0	8
10 Participation	1	3	1	2	1	1	9
11 Reintegration	0	1	0	0	0	1	2
12 Rights and discrimination	1	0	0	1	0	1	3
13 Unity	0	0	0	3	0	0	3
14 Representation	1	3	3	5	0	4	16
15 Voice	0	1	1	1	2	2	7
Total	10	16	28	21	15	19	109 (106)

Note. Numbers in brackets are corrected totals after taking into account repeated entries.

Table 3. Definitions and Examples of the ACTMHCN's Activities in Documents

Definition of Network activity (name of activity type in bold):	Examples from documents
1 Providing opportunities for members' feedback and reporting to members (accountability and consultation)	"Regular Consumer Forums were held to share information, experience and to identify common policy themes" (<i>Annual Report</i>); "Hold twice yearly member forums to gain feedback about the Network's work" (<i>Workplan</i>).
2 Specific tasks relating to representation, advocacy, and lobbying for policy change	"Submission to the review of the Mental Health (Treatment and Care) Act 1994" (<i>Annual Report</i>); "Network representation on committees" (<i>Annual Report</i>).
3 Good business practices to ensure a sustainable and professional organisation	"[The Network] achieved a substantial increase in its core grant for 2008-09" (<i>Annual Report</i>); "Improve staff and volunteer conditions" (<i>Workplan</i>).
4 Activities to build and utilise networks, connections and collaboration with others	"Projects for the year 2007-08 have included cooperative efforts with other organisations" (<i>Annual Report</i>); "[Send a] letter to organisations with pamphlet and invitation to become associate member of the Network" (<i>Workplan</i>).
5 Activities to educate and inform others on mental health consumer perspectives and convey consumer perspective to community, non-government and government organisations	"[Staff member] and I gave a lecture to second-year medical students at [university]... It went well, and I feel it gave the students an insight into the world of mental health consumers" (Chair's Report, <i>Annual Report</i>); "Deliver consumer research papers at conferences" (<i>Workplan</i>); "Conduct media interviews on issues of concern to mental health consumers" (<i>Workplan</i>).
6 Information sharing in providing resources to the public and as support for members	Examples include information items in the newsletter, drop-in and support group meetings, adding key resource documents to the Network's website; "The Network holds regular fortnightly forums on areas of interest including mental health programs and policy areas directly impacting on consumers" (<i>Annual Report</i>).
7 Strategies to boost membership of the Network and boost its visibility	Examples include holding fun runs, short story competitions and distributing flyers and newsletters widely.
8 Opportunities that increase knowledge and skills for members, including training and workshops, participation in educational activities and support for representatives	Examples include consumer advocacy training, media training, attending conferences, providing material support (e.g., a workstation) and other support (e.g., debriefing) for representatives.

Table 4. Number of Times Each Activity is Referred to in the ACTMHCN Documents

	Activity	Document					About Us	Total References
		Consti-tution	Annual Report	Workplan	Brochure	Newsletter		
1	Accountability and consultation	0	5	5	6	5	0	21 (13)
2	Representation, advocacy and lobbying	0	38	5	4	11	7	65 (51)
3	Good business practices	0	7	4	0	0	0	11 (8)
4	Collaboration	0	11	14	3	3	0	31 (29)
5	Educate	0	6	9	0	1	0	16
6	Information sharing	0	12	2	2	14	0	30
7	Boost membership	0	0	5	3	0	0	8
8	Training and support for representatives	0	12	16	2	1	0	31
	Total	0	91	60	20	35	7	213 (186)

Note. Numbers in brackets are corrected totals after taking into account repeated entries for the same activity.

Table 5. Definitions and Examples of the ACTMHCN's Values Identified in Documents

	The Network values(name of value in bold):	Examples from documents
1	Having input and accountability to members (e.g., through consultation , feedback and reporting)	“The Network provides mechanisms for the ... accountability for those in this role [of representative]” (<i>Annual Report</i>); “[The Network aims to build a professional organisation that ...is directed by and is accountable to its membership and wider mental health constituency” (<i>Workplan</i>).
2	Consumer knowledge and experience as an important resource and point for providing input	“Express the consumer voice” (<i>Newsletter</i> ; <i>Workplan</i>); “Unique consumer perspectives” (<i>Constitution</i>).
3	Determination and commitment by members and the ACTMHCN	“I am now determined to be an advocate” (quote by a representative, <i>Brochure</i>); “We all work hard to make changes and remind people that, despite having a mental disorder, we actually do need a voice” (Chair’s Report, <i>Annual Report</i>).
4	Personal emotions of dignity, pride, hope and empowerment shared among members and mental health consumers	“We have, thanks to the Human Rights Act, no excuse for allowing ourselves to pick up crumbs from the plate and then to tip our hats and say thank you. We will one day (soon, I hope), be able to say ‘This is what I want, when can you deliver?’ That would be Great!!” (Chair’s Report, <i>Newsletter</i>).
5	An inclusive , diverse and accepting culture and membership	“If you are interested in becoming involved in any of the Network’s projects and activities, please do let us know. You will be very welcome” (<i>Newsletter</i>); Another example is the grade of associate membership to allow for people who do not identify as mental health consumers to become Network members.
6	Information and informed opinion	“Provide accountable broad representation that is informed” (<i>Annual Report</i>); Another example is attending conferences.
7	Being a proactive and energised organisation	“Working proactively together to ensure provision of appropriate and timely support, assistance and treatment to mental health consumers” (<i>About Us</i>); “Build a dynamic...culture” (<i>Workplan</i>).
8	Respect in the organisation and community	“Working to advance [consumers’]... respect” (<i>About Us</i>).

9	Responsibility and professionalism in the sustainability of the ACTMHCN	“To govern the ACTMHCN in a responsible and sustainable way” (<i>Annual Report</i>); “The Network has established itself as a respected and credible player in the health sector” (<i>Annual Report</i>).
10	Principles of social justice including consumer participation, human rights and equality in the provision and accessibility of services and supports	“Social justice is the backbone of consumer advocacy” (<i>Brochure</i>); Other examples are representation activities, targeted areas of policy reform (e.g., advanced directives and involuntary treatment), and the promotion of participation in decisions and policy.
11	The development of members’ skills and strengths	“Deliver strengths-based individual and organisational skills development for consumer advocacy and representation” (<i>Workplan</i>).

Table 6. Number of Times Each Value is Referred to in the ACTMHCN Documents

	Value	Document					About Us	Total References
		Consti- tution	Annual Report	Workplan	Brochure	Newsletter		
1	Accountability and Consultation	6	3	1	2	5	0	17
2	Consumer knowledge	2	8	4	1	8	2	25 (23)
3	Determination and commitment	0	6	0	3	1	0	10
4	Dignity, pride, hope and empowerment	1	5	0	2	2	2	12
5	Inclusiveness	3	0	2	3	3	2	13
6	Informed opinion	1	14	2	2	8	0	27
7	Being proactive and energised	0	3	3	1	1	1	9 (8)
8	Respect	0	0	0	0	0	5	5
9	Being responsible and professional	5	10	4	0	0	0	19 (17)
10	Social justice	4	28	3	15	12	0	62 (58)
11	Skills development	0	2	2	1	0	0	5
	Total	22	79	21	30	40	12	204 (195)

Note. Numbers in brackets are corrected totals after taking into account repeated entries.