Young people's experience of discrimination in relation to mental health issues in Aotearoa New Zealand.

Remove the barriers for our young people from yesterday, today and tomorrow

Mental Health Foundation Research Report 2014

Mental Health Foundation
OF NEW ZEALAND
mauri tū, mauri ora
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LIKE MINDS, LIKE MINE
Whakaitia te Whakawhiu i te Tangata

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Foreword

The impacts of mental health concerns are often significant. For young people or rangatahi, these issues are typically magnified as they grapple with the challenges of modern life, the pressure to fit in, and the inevitable transition into adulthood.

This report highlights many of the challenges experienced by young people with mental health concerns. It reveals that discrimination, in particular, poses a real threat to their health and wellbeing – their ability to seek help, to express themselves, to negotiate relationships with others and to manage their lives. While the negative impacts of discrimination will often transcend age, gender, diagnosis or socioeconomic status, this report reveals that young people can face a unique set of pressures or circumstances, which serve to shape the manner in which discrimination is applied, perceived and ultimately impacts on their wellbeing.

Being young, Māori or Polynesian, gay or residing in a particular part of town, can expose young people to certain forms of discrimination and prejudice. These prejudices can likewise be amplified when young people are diagnosed with a mental health problem and yet another level of discrimination is expressed. They are likely to feel further isolated from the wider community, and exposed to unwarranted suspicion or ignorance, and ill-considered forms of banter, bullying, and remarks from peers or family members, which only serve to alienate them from valuable networks, groups and institutions.

Insofar as this report highlights the particular challenges faced by young people with mental health concerns, it also reveals what potential for positive change and growth exists. The report demonstrates that mental health and wellbeing, and pathways towards more positive outcomes, are not just the responsibility of the health and social sector. For young people, their relationships with their peers and family, and their community, sports and social institutions can be the catalysts for growth, and in many ways provide the foundation upon which more formal interventions are able to take root and flourish.

For these opportunities to be realised, the full impact of discrimination on young people must be considered alongside the multiple factors that either promote or impede positive outcomes. This report is a valuable resource in this regard and will not only assist with elucidating the issues, but more importantly, the potential solutions.

Ahakoa te momo mate, whakanuia tangata (regardless of illness or disease, people should be celebrated and valued).

Associate Professor **Te Kani Kingi** (Ngāti Pukeko)
Director Māori
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Preface

The Mental Health Foundation is proud to be part of the Like Minds, Like Mine programme to challenge stigma and discrimination and promote social inclusion through human rights.

This is the fifth research project that the Mental Health Foundation has undertaken as part of Like Minds, Like Mine, and the first exploration into the lived experience of young people. Previous research has explored different aspects of discrimination from the lived experience of adults, and the Like Minds, Like Mine programme overall has had largely an adult focus.

The research for this project was undertaken throughout 2010, and there have been a number of national policy and practice developments since then that are of particular relevance to young people. The most notable amongst these are the advancement of Whānau Ora as both a policy context and driver of change, and the measures to improve the mental health of young people initiated by the prime minister, the Honourable John Key, in 2012.

Whānau Ora provides the opportunity for an holistic approach – the clear need for which, by young people, has been made apparent throughout the current research. The Youth Mental Health Project initiatives provide a cross-government approach, and a package of measures to improve youth mental health. Although the age range (12 to 19 years) is slightly at variance with the research focus (18 to 24 years) there is sufficient overlap for the youth initiatives to be potentially very significant. There is no doubt that mental health issues are on the rise with the youth population.

The research projects that the Mental Health Foundation has undertaken have always been with a view to influence the wider policy underpinning, and the operational practices of, the Like Minds, Like Mine programme, in all its component parts.

There are insights and recommendations in the report that will touch on a range of settings and agencies. But the strongest theme is that the needs, views and voices of young people need to have a much greater influence on the design, planning and delivery of any anti-discrimination programmes for the future

We are indebted to the young people who gave their time and shared their experiences for this research; my thanks and appreciation go to each and all of them.

Judi Clements
Chief Executive
Mental Health Foundation of New Zealand

Executive Summary

Introduction

This research is part of the Like Minds, Like Mine programme to counter discrimination associated with mental illness (Ministry of Health, 2007). There is little available research about young people's experiences of discrimination associated with mental health issues. The research findings provide a knowledge base, which is grounded in young people's experiences within the New Zealand context.

The study sought to explore young people's (aged 18 to 24 years) experiences of the nature and impacts of discrimination associated with mental health issues, and to identify strategies to reduce discrimination from a young person's perspective. The research drew upon a qualitative methodology, and adopted a focus group method of data collection and a grounded theory approach to data analysis. Seven focus groups were undertaken, involving 30 young people from the greater Wellington region. The research was approved by the Central Regional Ethics Committee.

Understanding discrimination and mental health issues

Participants conveyed a diverse understanding of the meaning of discrimination and mental health issues. Young people widely regarded discrimination as something negative, involving unjust or unfair treatment, and being based upon some kind of difference. When asked about discrimination associated with mental health issues, most spoke of multiple forms of discrimination (e.g. racism, homophobia, being young) and did not view mental health issues in isolation from other forms of discrimination. Discrimination, as defined by the young people, also involved family violence, child abuse, parental alcohol abuse and bullying amongst peers.

Experiences of discrimination related to mental health

The different forms of discrimination experienced as a result of mental health included name-calling, belittling attitudes from others, and being excluded from either peer networks or specific settings (e.g. schools). The majority of young people reported experience of discrimination within the context of families and whanau, and amongst peers. It was also experienced within specific settings. These included schools (from both teachers and other students), when interacting with staff from government agencies (e.g. youth justice), and in healthcare settings (e.g. mental health inpatient units). The media was also seen to have a role to play in perpetuating multiple forms of discrimination against young people.

Impacts of discrimination

Young people reported diverse and serious impacts of discrimination on their lives and mental health. Being excluded, or singled out for adverse and unjust treatment over many years, combined with having little or no support from adults, resulted in immense anger for some young people. Aggressive behaviour towards others, a negative impact on their mental health (e.g. depression, low self-esteem), and increased drug and alcohol use were other identified

impacts. In addition, young people reported that the discrimination they had experienced had adversely affected their relationships with others, and sometimes resulted in a withdrawal from either peer or family networks.

Strategies to reduce discrimination

Strategies to reduce discrimination, and promote greater awareness of discriminatory abuse, mental health issues and diverse forms of discrimination, were explored in the research. A socioecological model provides a useful framework to conceptualise the spectrum of strategies young people identified. This model recognises the interconnected systems and social structures that shape young people's lives, and which young people can, in turn, influence.

Young people identified strategies for change across the socioecological model. At a macro level, the power and opportunities politicians have to champion and influence positive change in relation to mental health issues and to challenge discrimination was identified. The role of the media in promoting evidence-based knowledge about mental health issues, and in countering discriminatory attitudes about people who experience mental illness, was also highlighted – alongside the need for increased public education about mental health issues, as a way to increase awareness and reduce discrimination across communities. Change at an institutional level, such as among health services, the police and employers, was identified as an area where greater understanding of mental health issues and discrimination could be promoted. Some young people discussed the need to change certain practices and processes within these large institutions, to reduce discrimination and promote positive messages about mental health issues.

Key suggestions relating to families and whānau were the promotion of more effective communication amongst family members, and greater awareness of the impacts of child abuse, family violence, alcohol and drugs, and gambling and mental health issues. The promotion of a more inclusive school culture, and one in which diversity is 'fashionable', was identified as a key theme to reduce discriminatory abuse amongst peers. As in other spheres of the socioecological model, education about mental health issues and the impacts of discrimination were identified as a key strategy. Further, the provision of mechanisms to ensure teachers are well informed, and able to recognise and appropriately respond to all forms of discrimination, was recommended.

At an individual level, participants identified various actions they could take to counter discrimination. These included challenging the behaviour, developing friendships with people from diverse backgrounds, and being exposed to positive role models.

Chapter One

Introduction

"Children and young people have the right to protection from all forms of violence" – Article 19, United Nations Convention on the Rights of Children

Introduction

This chapter provides a brief account of the background and rationale for the project, locates the research within the broader context of work to reduce discrimination, and provides an outline of the research methodology.

Defining discrimination

The current research was designed to explore experiences of discrimination associated with mental health issues amongst young people (aged 18 to 24 years), and to identify strategies to reduce discrimination towards those who experience mental distress.

The terms stigma and discrimination are used interchangeably within the literature. Following the work by Peterson, Barnes and Duncan (2008), stigma is defined as the stereotypes, or negative beliefs and prejudice, held by most members of a social group about a minority group, usually incorporating a negative emotional reaction to the stereotype. Discrimination, however, is defined as the behaviour motivated by that prejudice. Discrimination occurs when a person is treated differently and unfairly (both directly and indirectly) from another person, in the same or similar circumstances (Peterson et al., 2008; Peterson, Pere, Sheehan, & Surgenor, 2004; Human Rights Commission, 2004), resulting in adverse consequences and effects on the person's life.

Young people's health status and outcomes

The World Health Organization identifies mental health conditions as a leading cause of preventable morbidity and mortality (World Health Organization, 2007). In any 12-month period, about 20 per cent of young people will experience a diagnosable mental health condition (World Health Organization, 2007). The likelihood of a mental health condition amongst young people is increased by the experience of 'violence, humiliation, devaluation and poverty' (World Health Organization, 2011). Poverty is also a key determinant of mental distress for children and young people (Mental Health Commission, 2011).

In 2006, there were approximately 757,000 young people aged 12 to 24 in New Zealand, which represents one-in-five of the total

New Zealand population (Ministry of Social Development, 2004). Research has identified that nearly one-third of young people aged 18 to 24 have a mental health issue[1] in a 12-month period, and young people in that age range have the highest 12-month prevalence of mental disorders for all age groups (Oakley-Browne, Wells, & Scott, 2006). Moreover, over one-third of young people in late adolescence have a clinically diagnosable mental disorder (Ministry of Health, 2011), with over half having it before the age of 18 (Mental Health Commission, 2011). Depression also affects at least one-fifth of New Zealand's young people by the age of 18 (Merry & Stasiak, 2011). The New Zealand Mental Health Survey notes that young people, Māori and Pasifika, and people living in areas of deprivation have a higher prevalence of psychological disorder than any other group (Oakley-Browne et al., 2006).[2] High rates of mental disorders and substance use disorders have also been reported for a cohort of 18 year olds in the Christchurch Health and Development Study, with elevated rates for rangatahi[3] (Horwood & Ferguson, 1998).

Compared with adults aged over 25, young people have a considerably higher prevalence of substance use disorder; and The Social Report 2010 indicates that young people aged 15 to 24 have the highest rate of potentially hazardous alcohol consumption (Ministry of Social Development, 2010). In 2010, a total of 27,268 young people aged 15 to 24 were seen by mental health and substance use services. Of note, is that New Zealand also has a high rate of youth suicide (Ministry of Social Development, 2010), particularly amongst rangatahi (Baxter, Kingi, Tapsell, Durie, & McGee, 2006), whose rate of suicide is 2.5 times that of non-Māori youth (Ministry of Health, 2012).

Despite the above, the proportion of young people accessing services remains lower than expected targets, and considerably lower than among adults in older age groups (Ellis and Smith, 2005; Mental Health Commission, 2007; Mental Health Commission, 2011). Access rates for all age groups are also lower in New Zealand than in countries with comparable resources (Mental Health Commission, 2007). Additionally, with child health having long-term consequences for health status and outcomes during adolescence and early adulthood (Mental Health Commission, 2007), it is important to note that New Zealand currently ranks 28th out of 30 OECD countries in terms of child health (Infometrics Ltd, 2011).[4] A recent report by the Office of the Prime Minister's Science Advisory Committee highlights New Zealand's unacceptably high rate of poor social and health outcomes in adolescence, compared with other developed countries (Gluckman, 2011).

The United Nations has previously identified discrimination, adolescent health outcomes, youth suicide and inequalities in social wellbeing as key areas requiring remedial action in New Zealand (McLaren, 2002). The need for a measurable improvement in young people's mental health has long been recognised in New Zealand youth health policy (Ministry of Health, 2002) and a recent report from the prime minister's chief science advisor signals an urgent need to improve young people's mental health and social outcomes (Gluckman, 2011).

Discrimination towards young people

Discrimination has been identified as a key factor contributing to young people's health outcomes (Gluckman, 2011). Discrimination is particularly marked amongst young people who occupy multiple marginalised positions (e.g. Māori and Pasifika) (Gluckman, 2011). Māori are more likely than any other group to report

[1] The terms 'mental illness', 'mental health disorder', 'mental distress', and 'mental health issues' are used interchangeably in this report. The young people's advisory group preferred the term 'mental health issues' so this term is most commonly used.

[2] The statistics reported in The New Zealand Mental Health Survey are likely to be an underestimate, because particular groups of people were not included in the survey. These included: (a) people residing in institutions (e.g. university hostels, sheltered accommodation, prison); (b) people who were homeless; (c) people who did not speak English, (d) people with a psychosis diagnosis, and (e) people under 16 years of age. Māori and Pasifika concepts of health were not included as part not speak English; (d) people with a psychosis diagnosis; and (e) people under 16 years of age. Māori and Pasifika concepts of health were not included as part of the survey.

[3] In the current research the terms 'young people', 'young person' and 'rangatahi' refer to those aged 18 to 24 years. 'Rangatahi' is used to explicitly refer to Māori young people.

[4] http://www.everychildcounts.org.nz/resources/learn-more-about-our-campaign-this-election/

racial discrimination, and there is evidence that Māori have poorer health status and inequalities in health outcomes compared with non-Māori (Harris et al., 2006). Lesbian, gay and bisexual young people have also been identified as a particular cultural group who are subject to widespread discrimination (McNair, Kavanagh, Agius, & Tong, 2005; Ryan & Rivers, 2003) and whose mental health is adversely affected by homophobia and discrimination (Rivers, 2001). Persistent victimisation in any form (e.g. to do with ethnicity, socioeconomic status or sexual orientation) can lead to a range of adverse mental health consequences, such as post-traumatic stress disorder, anxiety, depression, suicidal ideation and drug use (Ryan & Rivers, 2003).

Discrimination associated with mental health issues

Although there is limited research on adolescents' stigma experiences, when compared with the research available on adults (Moses, 2010; Hinshaw, 2005), a body of research indicates that discrimination associated with mental health issues is widespread and can exacerbate mental health problems amongst young people (Pinfold, Stuart, Thornicroft, & Arboleda-Florez, 2005; Romer & Bock, 2008; Thornicroft, 2008). Peers, families and school staff have been identified as holding negative assumptions and behaving in a discriminatory manner towards young people who experience mental health issues (Moses, 2010). For example, a study undertaken with 14 to 22 year olds found evidence that young people with mental illness were regarded as violent, dysfunctional and less able to do well academically (Romer & Bock, 2008). Of note, is that it has been identified that young people may experience higher levels of stigma compared to adults (Rose, Thornicroft, Pinfold, & Kassam, 2007; Young Minds, 2010; Thara & Srinivasan, 2000); and in New Zealand's report to the United Nations Committee on the rights of the child (Beals & Zam, 2010) discrimination against young people who experience mental health issues was identified by young people as a key area of concern.

A study undertaken in Scotland with young people who had experience of a mental health difficulty (either their own or a parent's), found that they were shunned by peers and were subjected to verbal and physical abuse. Furthermore, sympathy from friends and family was an additional source of stigma, and young people did not want teachers informed, as a means of avoiding being viewed differently (Woolfson, Menary, Paul, & Mooney, 2008). More recent research from the United States explored how young people who had been diagnosed and treated for 'psychiatric disorders' had experienced stigma, including from their family, peers, and within the school setting (Moses, 2010). Interviews with the youth (n=56) revealed approximately half describing experiences where they had been discriminated against in some way by family members (e.g. behaviours such as blame, avoidance or mistrust). Participants who identified substantial stigma within their family networks, reported being rejected, blamed or neglected by their families. Nearly two-thirds of the sample identified some peer stigma (such as being rejected by friends), and around one-in-three had experience of school staff treating them in a negative or demeaning way. Based on the findings from the research, the authors highlight the need for anti-stigma interventions with family and teachers (Moses, 2010).

Discrimination can prevent young people who experience mental health problems from seeking help (Barnett & Lapsley, 2006; Cauce et al., 2002; Thornicroft, 2008; Wisdom, Clarke, & Green, 2006). A review of the evidence regarding stigma concluded that y oung people's negative attitudes towards mental health may prevent them talking about their own mental health, due to a fear that they may be ridiculed or shamed (Young Minds, 2010). Some research suggests that there are gender differences in relation to attitudes about mental health issues, which impact on young people's help seeking (Chandra & Minkovitz, 2006). In comparison to young women, young men are reported to experience more stigma, and have less knowledge and awareness of mental health issues, and to be less likely to talk to a friend or to seek professional help (Chandra and Minkovitz, 2006). However, young men are more likely than young women to talk to a family member about mental health issues. Stigma also influences young people's perceptions of mental illness and suicidal behaviours (Bennett, Coggan, & Adams, 2003). Other impacts of stigma include a loss of self-esteem (Young Minds, 2010) and reluctance to admit the existence of mental health problems (Young Minds, 2010; Woolfson et al., 2008).

When considering the attitudes of young people themselves, recent research from Australia found that young people associated all mental illness with 'unpredictability', and stigmatising attitudes were associated with particular diagnoses (Reavely & Jorm, 2011). Other research has identified that young people may have negative attitudes towards people with mental illness (Rose et al., 2007; Pinfold et al., 2005; Pinfold et al., 2003; Parle, 2012). A study undertaken in the United Kingdom found that, when young people were asked what sort of words or phrases they might use to describe someone with mental health problems, over half of the words reported were 'popular derogatory terms' (e.g. nuts, psycho, crazy) (Rose et al., 2007).

Given that young people may go on to experience mental health issues themselves, (Pinfold et al., 2005; Bailey, 1999), the importance of targeting this population group with educational programmes and anti-stigma interventions has been recognised (Pinfold et al., 2005). Of note is that short educational workshops within schools have been shown to be effective in facilitating positive changes in young people's perceptions of mental illness (Pinfold et al., 2005; Pinfold et al., 2003), and the need for whole-school strategies to support the emotional wellbeing of staff and pupils within schools has been highlighted (Pinfold et al., 2003).

While there is an emerging body of international research that reports on the provision of educational programmes for younger people that aim to reduce their stigma and discrimination towards others with a mental health problem (Pinfold et al., 2003; Rose et al., 2007), there is very little research specifically about discrimination towards young people within the New Zealand context (Mental Health Foundation of New Zealand, 2004).

New Zealand research

A study undertaken in 2010 identified that young people with mental health issues had experienced stigma and discrimination in a variety of settings, including schools, sports groups, health services and in the media – as well as from friends and family (McKay & Bagshaw, 2010). Negative experiences included receiving inadequate information from health practitioners; not being listened to; bullying, teasing and gossip; and a lack of support from teachers. A range of subsequent impacts were reported, including reduced self-esteem and an avoidance of social situations, and the research highlighted the need for education within schools (for both staff and students) (McKay & Bagshaw, 2010).

Other research (Mental Health Foundation of New Zealand, 2004) conducted with New Zealand tertiary students, explored how young people without experience of mental illness perceived young people with mental health issues. The study found that participants' understanding of mental illness was fairly broad and vague, and often confused with learning disabilities and other disorders. Discriminatory attitudes and behaviour were evident in young people's recall of school-based experiences where people with experience of mental illness were segregated or socially excluded. The research also identified a perceived link between those who are mentally unwell and a risk of danger and physical violence, even though it was reported that none of the study participants had first or second-hand experience of this (Mental Health Foundation of New Zealand, 2004).

Research and evaluation tracking changes in people's attitudes towards and knowledge about mental health and mental illness in New Zealand suggests that young people's knowledge and attitudes improved in the years between 1997 and 2004 (Fern, Goodman, & Wyllie, 2006). In particular, improvements in young people's attitudes towards people who experience mental illness were identified. Education at school was the most commonly reported source of knowledge about mental health issues. However, there were still gaps in young people's knowledge, and negative attitudes towards people who experience mental health issues. The report identified that young people had a much lower awareness of mental illnesses than the adult population, and were much more likely than older age groups to hold unsympathetic attitudes about people who experience mental health issues (Fern et al., 2006).

Locating the research

The Like Minds, Like Mine programme

The Like Minds, Like Mine National Plan 2007-2013 (the Like Minds, Like Mine Plan) recognises that discrimination associated with mental illness is harmful and a health concern (Ministry of Health, 2007). The research presented in this report is part of a Like Minds, Like Mine programme of work to reduce stigma and discrimination associated with mental distress. An integral aspect of the Like Minds, Like Mine Plan is to change discriminatory attitudes and behaviours, promote human rights and reduce discrimination at all levels of society (Ministry of Health, 2007).

The Like Minds, Like Mine Plan is informed by a human rights philosophy that recognises the 'dignity and value of all people and the right to be free from discrimination' (Ministry of Health, 2007). A key tenet of the programme is to advance the rights of people who experience mental distress. While the Like Minds, Like Mine programme has historically focused on the adult population, the rights of young people are implicit in this guiding framework. Further, the plan recognises the need to ensure specific approaches to programme delivery for Māori and Pasifika (Ministry of Health, 2007).

A range of studies have been undertaken by the Mental Health Foundation as part of the New Zealand Like Minds, Like Mine programme. These include two prominent studies: a national survey of adults' experiences of discrimination (Peterson et al., 2004), and research about discrimination within and towards families and whānau (Barnett & Barnes, 2010). Other research has also highlighted discrimination in a New Zealand context. However, a lack of knowledge about young people's experiences of discrimination has only more recently been identified as a significant gap in the evidence base about discrimination associated with mental health issues. A focus on specific population groups, including young people, is now incorporated as a key approach in the current Like Minds, Like Mine Plan (Ministry of Health, 2007).

In response to this identifiable knowledge gap, the current research was designed to explore experiences of discrimination associated with mental health issues amongst young people and to identify strategies to reduce discrimination towards young people who experience mental distress.

Project team and consultation process

The research team consisted of the principal researcher and a Like Minds, Like Mine mental health promoter, both employed by the Mental Health Foundation, and a young person working in the mental health sector who identified as Māori and Pasifika. All members of the research team were women. An advisory group of young people, and older Pasifika working in the mental health sector, was established and this group provided advice throughout the course of the project.

The project was overseen by the Mental Health Foundation's cultural advisor. The research process was also guided by Nga Kai Tautoko – a group of cultural advisors who are leaders in the mental health sector. Nga Kai Tautoko facilitated engagement with Ngati Toa Rangatira kaumatua to enlist support for the research with rangatahi

in the local area, and liaised with kaupapa Māori organisations to enhance engagement with rangatahi. Nga Kai Tautoko also provided cultural guidance to the research team and advisory group, and facilitated kaupapa Māori processes and protocols for all Māori-specific focus groups.

Aims and purpose

The goal of the research was to explore young people's (aged 18 to 24) experiences of discrimination associated with mental health issues, with a view to reducing this form of discrimination as a barrier to recovery for young people.

The aims of the research were to:

a) explore the impact of discrimination associated with mental health issues from the perspective of rangatahi or young people

b) better understand the relationship between rangatahi or young people's experiences of discrimination and mental health issues.

The purpose of the research was to:

a) make recommendations on ways to reduce discrimination associated with mental health issues from the perspective of rangatahi or young people, with particular attention to strategies appropriate to Māori and Pasifika

b) make recommendations on how organisations can ensure that young people who experience mental health issues are not discriminated against

c) provide an evidence base to inform broader policies and practices that impact on young people's lives and wellbeing

d) provide an evidence base to inform Like Minds, Like Mine education and training about how society can better value and include young people who experience mental health issues

e) make recommendations on ways to reduce discrimination related to having a family or whānau member who experiences mental health issues, from the perspective of young people or rangatahi.[6]

Methods

The research adopted a qualitative approach, consisting of a series of focus groups undertaken with young people. Details of the research methods are provided below.

Inclusion criteria
All participants were required to be aged 18 to 24 years, with experience of discrimination in relation to mental illness. To ensure appropriate representation of rangatahi, and to adequately address issues of equity in relation to discrimination and mental health outcomes for Māori, some of the groups were Māori-specific.

Due to ethical requirements, young people who were currently residing in a district health board mental health inpatient service, or who could ethically or legally be deemed to be minors, were not included in this research. In addition, because of logistical and financial constraints, only people who could communicate in the English language were eligible to take part in the research.

Recruitment
Participants were recruited via networks of the Mental Health Foundation, Nga Kai Tautoko and the young people's advisory group. This involved a range of organisations working with young people in the greater Wellington region, which were consulted about appropriate processes to engage young people, informed about the research, and asked to assist by informing young people and encouraging participation.

Posters relevant to young people were developed and widely distributed. Electronic copies were sent to key networks and support organisations, and printed posters were put up in public places

[6] Due to challenges associated with recruiting young people who have a family or whānau member who experiences mental health issues, this part of the research was not undertaken.

and local shops and in organisations working with young people.

Data collection
The research comprised of a series of focus groups, which explored young people's experiences of discrimination associated with mental health issues. Focus groups have been described as a form of group interview with a number of key characteristics (Bryman, 2008). These characteristics are:

i. the topic of inquiry is well defined

ii. several people participate in each focus group

iii. participants have particular experiences in common

iv. the group constructs and defines meaning

v. participants have the opportunity to focus on issues that they regard as important

vi. the discussion is an interactive process between participants.

Focus groups were co-facilitated. The focus group facilitators – all members of Nga Kai Tautoko, the advisory group and the research team – attended a one-day research training workshop. The workshop addressed the research's aims, purpose, processes and ethical requirements. Each focus group was led by a member of the research team or Nga Kai Tautoko, alongside a young person from the advisory group.

Kaupapa Māori processes were used in the rangatahi focus groups. Each focus group began with some form of introduction and an ice-breaker. All participants were given an information pack, which included: (a) an information form; (b) a consent form; (c) a Code of Health and Disability Services Consumers Rights brochure; and (d) Mental Health Foundation discrimination fact sheets; as well as various Mental Health Foundation pens and magnets. Each focus group started with a discussion about the meaning of 'discrimination'. The Human Rights Commission definition of discrimination[7] (see Appendix C) was subsequently placed on the wall and given to participants to refer back to during the focus group discussion. In some groups, the meaning of the term 'mental health issues' was also explored.[8]

A key questions guide (see Appendix D) was used consistently by facilitators in all focus groups. The key question areas included the meaning and experience of discrimination, sources and impacts of discrimination, and strategies young people believed would be effective in reducing discrimination.

Co-facilitators took notes during the focus groups to enable individuals to be identified when reading the transcripts, and to note key themes and observations. All focus group discussions were digitally recorded and later transcribed verbatim. Facilitators also wrote summary reports following each focus group. Each of these data sources was used during the data analysis process.

Focus groups were conducted across the greater Wellington area, including Porirua, Wellington and Wairarapa. This region was selected because:

i. it includes a diversity of young people (Māori; Pasifika; refugee background; areas of low and high socioeconomic status; urban, rural, provincial)

ii. it includes areas with a disproportionately high population of young people

iii. the Mental Health Foundation has established networks in this region

iv. it is easily accessible.

[7] Human Rights Commission. Fact sheet 4: Discrimination by the public sector. Retrieved from http://www.hrc.co.nz/resources/.
[8] Some participants were unclear about the meaning of 'mental health issues' or 'mental illness' and this was also discussed at the start of the focus groups.

Definition of discrimination adopted in the research

At the beginning of all focus groups, participants were asked about the meaning of discrimination and how they understood this term in relation to mental health issues. Initial questions about the terms gave participants an opportunity to provide a self-defined meaning, without the constraints of a prescribed definition. However, following this, facilitators presented the following commonly used definition of discrimination from the New Zealand Human Rights Commission: "discrimination is being treated unfairly or less favourably than another person in the same of similar circumstances".[9]

The reasons for using a prescribed definition as part of focus groups discussions were two-fold. Firstly, in previous Mental Health Foundation research (Barnett & Barnes, 2010) participants' ideas about discrimination sometimes extended beyond a commonly accepted understanding of the term. While a range of adverse attitudes and behaviours reflect abuses of power, or abusive ways of treating people, they do not always reflect discrimination or being singled out for particularly negative treatment. This meant there was the potential to produce findings that had little relationship to the aims of the research. This issue is discussed further in Chapter Three, as part of reporting young people's experiences of discrimination.

Secondly, in the current project, the research team and advisory group had anticipated that some young people might not be familiar with the term discrimination. It therefore seemed appropriate to provide a definition that would be easily understood and useful for participants to refer to throughout focus groups. Hence, the Human Rights Commission definition (as above) was used in all groups to prompt discussion about discrimination.

Data analysis

A grounded theory approach was used to analyse the research data. Grounded theory has been defined as theory or concepts "derived from data, systematically gathered and analysed throughout the research process" (Strauss & Corbin, 1998, cited in Bryman, 2008, p. 541). The use of multiple data sources, and lengthy transcripts based on multiple speakers, can be challenging to analyse. However, the three research team members worked independently to code the data and identify key themes. The team subsequently met to discuss the findings that had been individually generated. This process provided a mechanism to ensure the reliability of data interpretation. The Māori research assistant was also supported by Nga Kai Tautoko to interpret the data from the rangatahi focus groups. This approach enhanced the interpretation of rangatahi experiences from a te ao Māori standpoint. Although the total sample size was relatively small, similar themes recurred across groups, suggesting that theoretical saturation was achieved.[10]

Ethics and ethical approval

The Mental Health Foundation is committed to the Treaty of Waitangi and recognises Māori as tāngata whenua. The research team had a strong commitment to kaupapa Māori processes, youth development principles, consumer-driven research and comprehensive research ethics. They also recognised the unique status of mana whenua or indigenous people whose ancestral land is the local area.

The research and all protocols used in the focus groups were informed by the following ethics guidelines.

i. Guidelines on Ethics in Health Research (Health Research Council, 2005).

ii. Guidelines for Researchers on Health Research Involving Māori (Health Research Council, 2008).

iii. Te Ara Tika Guidelines for Māori Research Ethics (Health Research Council, 2010).

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[9] Human Rights Commission. Fact sheet 4: Discrimination by the public sector. Retrieved from http://www.hrc.co.nz/resources/

[10] Theoretical saturation is defined as the 'point when emerging concepts have been fully explored and no new insights are being generated' (Bryman, 2008, p. 700).

iv. Ethical Research with Mental Health Consumers (Peterson, 1999).

v. Code of Ethics for Youth Work in Aotearoa New Zealand (National Youth Workers Network Aotearoa Inc., 2008).

A standard information form (see Appendix A), which was consistent with Human Rights Commission guidelines, was distributed and read out to participants in each focus group. Consent forms were read and signed by all participants (see Appendix B). The Code of Health and Disability Services Consumers' Rights brochure was distributed in all focus groups.[11]

The research was approved by the Central Regional Ethics Committee.

Report layout

This first chapter has provided a brief account of the background and rationale for the project. It has located the research within the context of work to reduce discrimination associated with mental illness and a broader literature relating to young people's mental health and social outcomes. An outline of the research methodology has also been provided.

Chapter Two, the first of the findings chapters[12], focuses on participants' understandings of the meaning of discrimination and mental health issues.

Young people's experiences of discrimination within the context of mental health issues are reported in Chapter Three.

Chapter Four provides an account of the impacts of discrimination on young people's mental health and other areas of their lives.

Strategies to reduce discrimination identified by participants are reported in Chapter Five.

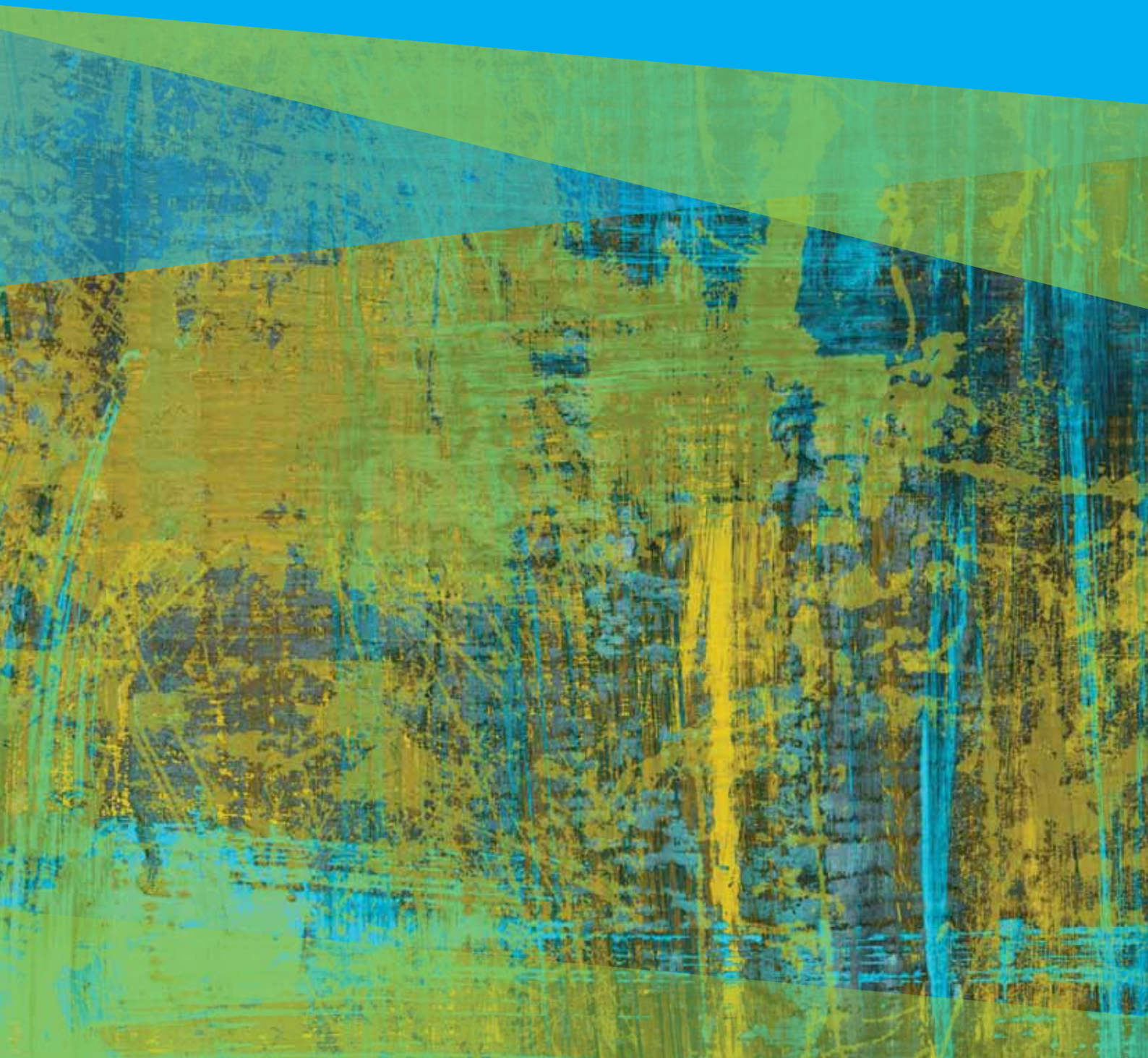
Chapter 6 provides a discussion of the findings in the context of the barriers that young people experience, and how to better understand and reduce discrimination in ways that are culturally relevant to young people's lives and social contexts.

[11] The full code can be read online at http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full) (Health and Disability Commissioner, n.d.).

[12] The results section of the report is interwoven with quotes from the young people to illustrate their experiences. We use the young people's own uncensored language, some of which the readers may find offensive. However, we have authentically reported words and phrases used by participants to convey the rawness of the experience.

Chapter Two

Understanding discrimination and mental health issues



"Discrimination ... starts playing with your mind and getting to you real bad" – Participant

Understanding discrimination and mental health issues

Description of the sample

Seven focus groups, involving 30 participants, were undertaken.[13] Three focus groups were Māori-specific, and four were general or non-specific.[14] This included:

- N= 3 Māori-specific (rangatahi) groups:
  - n=1 Wellington
  - n=2 Porirua[15]
- N= 4 general (non-specific) groups:
  - n = 2 Wellington
  - n= 1 Wairarapa[16]
  - n= 1 'rainbow'[17].

Māori-specific focus groups

Many of the participants in the Māori-specific focus groups were in contact with youth justice services. The cultural advisors to this research, who also worked in the local mental health sector, liaised with relevant kaupapa Māori organisations to recruit young people with experience of mental health issues. The participation of these young people in the research reflected the support provided by staff in Kaupapa Māori organisations connected to youth justice services, who encouraged rangatahi to participate. Five participants in the Māori-specific focus groups identified as parents.[18]

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[13] We had intended to recruit 70 to 80 young people to take part in the focus groups. The fewer number of participants, and other research limitations, are discussed further in Chapter 6, the discussion section of the report.

[14] Attempts to recruit young people with a refugee background and Pasifika youth were unsuccessful, and thus focus groups with these young people did not eventuate.

[15] One young person who attended this focus group identified as Pākehā.

[15] Three young people who attended this focus group identified as Māori.

[17] The term 'rainbow' encompasses young people who identify as lesbian, gay, bisexual, takataapui, fa'afafine, transgender and intersex. This group was also undertaken in Wellington.

[18] This information was gathered from the demographic information provided by participants. However, only three participants in these groups spoke of being parents.

General focus groups

The four general focus groups consisted of young people who had been in contact with mental health services. The nature of contact with some services meant that some of the young people knew one another. Seven participants from the general focus groups identified that they had family or whānau who experienced mental health issues. Many of the participants in the general focus groups knew about discrimination in relation to mental health issues or other issues of difference. Some participants were actively involved in efforts to reduce discrimination (e.g. a district health board consultation group; the Queer Youth Alliance). One person in the general focus groups identified as a parent.

Table 1 provides an overview of the sample in terms of its demographic characteristics.

Table 1: Demographic profile of focus group participants

Characteristic		Number (n=30)
Gender	Women	13
	Men	16
	Unknown	1
Age (years)	18	8
	19	7
	20	2
	21	6
	22	3
	23	0
	24	1
	Unknown	3
Ethnicity*	New Zealand European/Pākehā	14
	Māori	14
	Pasifika	3
	Other	1
	Unknown	2
Focus group type	General	16
	Māori-specific	14

*Four people identified with two ethnicities

Discrimination and mental health issues

This section explores participants' understanding of the terms discrimination[19] and mental health issues. While these terms are commonplace in the mental health sector, feedback from the research advisory group indicated that they were not likely to be familiar to young people. A key part of the focus groups, therefore, was to gauge participants' understanding of these terms; not to determine whether their interpretation was correct or consistent, but rather to identify how they understood and used language associated with mental health issues and discrimination. This information is critical to engaging young people and developing strategies designed to reduce discrimination towards this particular population group.

It is important to highlight that, in the current research, participants were consistently and explicitly asked questions about discrimination associated with mental health issues. When the young people's discussions veered away from this topic, facilitators made significant efforts to reorient the groups to the aims of the research. However, while the core research questions focused overtly on discrimination associated with mental health issues, the young people taking part in this research spoke of multiple forms of discrimination (e.g. related to physical appearance). Moreover, when discrimination as it pertained to mental health issues was discussed, the following two themes were identified as discrimination by participants across most focus groups:

- child abuse and family violence
- emotional abuse and physical violence from peers.

The unexpected nature of these findings, and the unanticipated focus on these issues by participants, led to considerable discussion within the advisory group. It was agreed that although the findings did not readily correspond with the stated aims of the research, the only ethical approach was to interpret, contextualise and report the findings in accordance with participants' testimony and experiences. This document maintains a focus on discrimination[20] (as previously defined) experienced by young people as a result of mental health issues.

Participants' understanding of discrimination

Participants conveyed a range of understandings of the meaning of discrimination and mental health issues. However, there was a shared notion that discrimination involved something 'negative', a 'judgement,' 'put downs' and being 'shut out' because of being different in some way. Many young people spoke of 'injustice' and being treated 'unfairly' compared with others. One young woman described discrimination as, "people having a judgement on something particular about you that's negative ... and they treat you in a particular negative way based on that negative judgement". Another regarded discrimination as, "people picking on you, they maybe judge you too harshly [or are] overcritical".

For many young people, discrimination was simply defined in terms of 'being different', being 'excluded from a group' and not belonging. Being 'different' ranged from the seemingly innocuous, such as wearing 'different clothing', 'looking different' or 'being different', to having a physical disability or learning disability, being overweight, or having mental health issues. Sometimes discrimination was connected to particular behaviours, such as those associated with 'attention deficit disorder'. The way in which discrimination was described often included

[19] As noted in the methods section, the Human Rights Commission's definition of discrimination was used to prompt discussion about discrimination. The use of a concrete definition was especially useful with two participant groups, who were not only unfamiliar with the term 'discrimination', but were also unused to talking about mental health issues amongst peers. Many participants in these two groups had initially been quite reticent. However, the use of a clear definition, presented as a visual prompt, and some real-life examples of discrimination provided by facilitators, enabled engagement with young people as the focus groups progressed.

[20] As highlighted, the young people spoke of multiple, coexisting forms of discrimination, and many reported discrimination in the context of child abuse and family violence, as well as emotional and physical abuse at school. Because of the inextricability of discrimination and abuse in some cases, and the pervasiveness of this form of discrimination amongst participants in this research, the term 'discriminatory abuse' is used in this report to convey this dynamic.

accounts of experiences of emotional abuse and physical violence, referred to as being 'mentally abused' and 'bullied'.

It is important to note that discrimination was widely associated with a range of issues, such as being treated unjustly or unfairly due to being a young person, being Māori or Pasifika, being gay, having a physical disability or medical condition, or living in a low socioeconomic area. Indeed, for the majority of young people, discrimination was not solely about mental health issues. One young woman described discrimination as, "someone being prejudice or negatively looking at you … and your kids". Another young woman spoke of discrimination in the following way:

[T]here's … a whole lot of meanings to that word … [it's] about culture … looks … how we present ourselves … power … [being] Muslim and people immediately think something bad [of you] … also gender and sexuality … it's really hard to become who you want to be without being judged … youth get pressured so much.

Indeed, discrimination solely related to mental health issues was rarely included by the majority of participants during focus group discussions about the meaning of discrimination. This reflects young people's multi-dimensional interpretation and experience of discrimination, as explained above. However, when discrimination specific to mental health issues was spoken about, it was described in ways that were clearly about the young person's mental health status.

A young woman from a provincial area commented, "it's when people call you mental … they don't really know what you have been through.' A young man from the same area commented, "it's when you're treated differently or separated from everyone else … because of what you've been through or because of depression or something else'. Some participants appeared to confuse mental illness or mental health issues with learning disabilities and intellectual or physical disabilities. Where possible, this report focuses on discrimination as it pertains to mental health issues.

Differences across young people

The study identified some differences in the way in which discrimination was viewed and conceptualised across the research participants. Findings from the research suggest that these were influenced by participants' social backgrounds and the impact of exposure to different service types, as detailed below.

Most of the participants who attended the general focus groups were using (or had used) mental health services, with the majority identifying as young Pākehā women. Both male and female participants in these groups who had contact with mental health services spoke of the ways their mental health issues had developed in response to adverse childhood experiences in the family or whānau, or pervasive emotional abuse or physical violence at school.[21]

Most of the young people in the Māori-specific focus groups were currently using youth justice services. Most male participants in these groups who had contact with kaupapa Māori[22] youth justice services regarded the term 'discrimination' as 'a big word'. Although most did not use the term discrimination in their day-to-day lives, they conveyed an inherent understanding of discrimination, based on their lived experiences of 'unjust' or 'unfair' treatment. The focus for these participants was on discrimination experienced in relation to factors such as being singled out for adverse treatment within family or whānau, or being treated unfavourably by police, due to being seen as young and Māori or Pasifika. While discrimination was unfamiliar terminology, the lived experience of discrimination was, nonetheless, commonly understood and regarded as part of 'everyday life'. The background of the sample may not be

[21] These four groups, by ethnicity, included: 12 Pākēha, three Māori, one Pasifika, and one 'other'. (Note that two people identified with two ethnicities.)
[22] Founded upon Māori knowledge, principles and practices.

wholly representative of young people in some respects, but mental health issues are on the rise within the youth population, and many young people experience mental health issues without having been abused or being within the youth justice or Child Youth and Family service (CYFS) systems.

Talk of 'mental health issues' or 'mental illness' amongst most male participants in the Māori-specific focus groups was rare. Most did not talk about mental health issues or convey that they saw themselves as having problems with mental health. However, four people mentioned being diagnosed with mental health problems, and two people referred to family members with experience of mental illness. One rangatahi conveyed that it was not usual or comfortable to talk about these issues with 'the bro'.[23] Many described themselves as having been 'little shits' when they were young. Most had been under CYFS care and had been to family group conferences, as they had been subject to child abuse and family violence. Few connected their behaviour (i.e. 'being little shits') to surviving childhood adversity. Two young women in these groups, who had been in contact with mental health services, were highly articulate and confident talking about discrimination and mental health issues. Three young men in one of the Māori-specific focus groups were not from youth justice services, but instead were in contact with a mental health service; however, they rarely spoke in the group and it is not possible to report their perspectives.

[23] Talking with peer-aged males – the 'brotherhood'.

Chapter Three

Experiences of discrimination

Mole face
Fuckwit
Loser
Mental Case
Faggot

Experiences of discrimination

This section discusses dominant themes relating to experiences of discrimination linked to young people's mental health issues. As discussed previously, some young people were explicit in their use of the term discrimination, whereas others, who were less familiar with the term, used other language to report discriminatory behaviour. The different forms of discrimination experienced as a result of mental health issues included name-calling, belittling attitudes and being excluded. These are outlined below, followed by a discussion of discriminatory experiences as they pertain to specific settings.

Name-calling

Young people's discussions about discrimination identified that they had been subject to name-calling. While this was sometimes particular to their mental health, it was also associated with a range of other issues. Almost all participants reported that they had been subject to taunts themselves involving name-calling, and had witnessed other people being subject to similar 'put downs' – both in families and whanau, and amongst peers. Some of the name-calling the participants reported included crazy, mental, mental case, nutter, retarded, schizo and weird.

Name-calling was regarded by many participants as a 'normal' part of family or whānau life and school culture. One participant spoke of multiple names she was called by peers and ongoing discrimination related to mental health issues, "I was getting bullied, they called me mental and all that ... and I was being called a slut, a slapper".

Recalling discrimination that occurred in a small provincial high school, one young man who described himself as having 'ADHD' spoke of discrimination he was subjected to by peers. This included being called a range of names. A young woman in the same focus group, who went to school with this young man, had witnessed him being bullied on many occasions. She told the

group that other students would say things to him such as, "you're a fuckwit, you're a faggot, you can fuck off, you don't belong here". She said they would, "tease him ... constantly, every day".

Belittling attitudes

Experience of belittling attitudes from others was also reported in the research. This included derogatory comments, and rumours with no substance being circulated around school and other youth networks. For many participants, being 'verbally picked on' and being the subject of 'nasty rumours' relating to all kinds of difference were daily experiences of discrimination. As one young woman said, "there were times at school when people picked on me quite severely and [the] abuse ... [it] belittles people".

Following contact with mental health services, a young man who had attended a city high school told of the stress suffered when he was subjected to numerous and repetitive false rumours by peers, as well as various name-calling:

It was heaps of people ... they were like ... calling me ... 'a mental case' ... a rumour went around that I was hitting my mum ... they were calling me 'a crack addict' ...a rumour went around that I was smoking P.[24] Don't know how a 13 year old gets P ... they went around saying I was an alcoholic, because, I'd drink every now and then ... there were stories that went around that I stole money, stole cars ... I killed our cat ... it started getting to me because people just kept on going and going and going and going ... people go ... 'you're such a loser'.

Some young people said their friends made unintentionally hurtful and insidious comments that related to their mental health status. For example, friends made comments that implied the young person was 'getting unwell' or behaving in a certain way because they were 'unwell' – rather than the way the young person was behaving being seen in the same way as anyone else's repertoire of behaviour. One participant recounted feeling discriminated against by the attitudes of her friends towards her:

[A] couple of girls are more recent [friends] and I felt it necessary ... [to] ... tell them about my past ... it's quite annoying because I'll be in the kitchen with a couple of them and if they see me with a knife they'll start acting quite weird and try and take the job that uses the knife, over to them.

While not widely reported, discrimination associated with flatmates was noted; this included negative assumptions and derogatory comments. For instance a young woman, who described herself as being depressed, often stayed in her room. When her mood lifted, she once again became engaged in activities and the outside world. However, her flatmates made derogatory comments suggesting she didn't have any interests, rather than realising she was, in fact, 'struggling' with life.

Exclusion

Young people reported being shunned or experiencing exclusion from particular settings, due to their mental health issues. As evident in the examples below, this was sometimes in response to their behaviour; in other cases, young people were excluded due to others' knowledge of – and subsequent reaction to – their mental health issues. One young person talked about having 'a major manic episode' and having said 'rude things' to friends because she 'was totally out of it'. Since coming out of hospital she had tried to apologise to these people and conveyed the anguish associated with trying to make amends when friends were not responsive:

[W]hen I was coming ... out of hospital ... and trying to reconnect with those people to say sorry, I never really got a response ... I'd like for people to be able to understand ... to listen to what I have to say and say sorry because it's not

[24] 'P' is a common street name in New Zealand for methamphetamine.

like I wanted to be like that … I did things I didn't want to do to people and hurt them … that's unresolved.

One young woman from a provincial high school spoke of discrimination associated with mental health issues, including how others at school knew when a young person was experiencing difficulties. As evident in the following extract, this sometimes resulted in being shunned by peers:

[S]ome people just ignore you 'cos they know [you have mental health problems] … because you're always with a guidance counsellor or you always have a mentor … a support worker.

A young woman described discrimination she experienced at a private school, where the school authorities refused meetings with her and her parents, and also refused to meet the case manager from the young woman's mental health service. Later, a 'blanket ban' was instituted, so that neither the dean nor teachers were permitted to meet the young woman or her parents:

I was discriminated at school for mental health stuff … initially I had heaps of support from teachers … after a while it got like, 'this is too much for us to deal with'. So they sent me for a psychiatric assessment and told me I couldn't come to school. Then they sent a letter to my parents saying 'if she doesn't get better she has to leave the school' … you couldn't say that to someone who had cancer.

A minority of participants said they had disclosed their experience of mental health issues when they applied for flatmate positions. When the young person did not get accepted into a flat, it was difficult for them not to assume that this was because of the disclosure.

Other forms of discrimination

This section reports participants' experiences of discrimination that sit outside of the definition adopted for the research study. As highlighted previously, young people's interpretation and discussion of discrimination was multi-dimensional; this section provides a brief summary of some of the key issues raised.

Various forms of discrimination occurred in the context of families and whanau.[25] These included family violence and child abuse, abuse from step-parents, parental alcohol abuse, family violence and child abuse involving CYFS[26] intervention, parent to child hostility, being shifted around caregivers, discrimination connected to body size, and unresolved parent–child hostility as young people entered adulthood. Young people reported that these multiple factors contributed to their mental health problems, led them to leave home at a young age, and sometimes resulted in them limiting contact with their family or whānau. Moreover, family violence, child abuse and being a specific target of abusive treatment with the family or whānau were interconnected. This meant that these experiences were not regarded as separate entities, but rather a collective environment of discrimination.

Young people across the focus groups spoke of child abuse, combined with 'being singled out' or 'targeted' within the family or whānau, and being subject to hostile or overtly abusive treatment by parents. Emotional and physical abuse also occurred in the homes of step-parents and homes young people were placed in following CYFS intervention. For many, discrimination within the family or whānau occurred within a broader context of family violence, where being 'bashed' or getting a 'hiding' was seen as 'normal'. Indeed, the young people's childhoods were often characterised by family violence, and the conflict and chaos resulting from parents who abused alcohol. One woman spoke of the impact of growing up in this environment and the persistent friction within her family that was fuelled by alcohol:

[My mental health problems] started … in the family, it's not a nice place and I try to keep away from it as much as I can … there's something

[25] Due to the pervasiveness and inextricability of discrimination and abuse the term 'discriminatory abuse' is used in this report to talk about participants' experiences of this type of discrimination.

[26] Child, Youth and Family services.

always going wrong, they are always drinking constantly ... I know what it leads to, arguments ... major dramas ... they are just bad, nasty [people].

A key aspect of the young people's talk of discrimination was that they were singled out in some way, often resulting in particularly harsh abuse. For example, several young people spoke of a parent, parents or step-parents who did not like them, and of how family or whānau members routinely spoke to and treated the young person in a negative or hostile manner, or blatantly ignored them. In these ways, the young person was treated adversely and differently from siblings or others living in the family or whānau. One young man had been subjected to considerable hostility since he was very young and, following a referral to mental health services and a 'mental illness' diagnosis, the young man was 'kicked out of home' by his parents. He was put into a CYFS home and then started living on the streets.

It is important to note that, while many of the young people spoke of historical child abuse in their families or whānau, several also spoke of current and ongoing abuse that they are subjected to.[27] Indeed, for many, relationships with a parent or parents remained fractured. This was especially so for those who had a parent who was particularly abusive, where the parent had never liked the young person, or where a parent was now in a new relationship with another adult who abused the young person. These experiences of abuse within the family or whānau were regarded by the young people as forms of discrimination, which continued to cause distress.

Other issues discussed in relation to discrimination that were outside the scope of the research included discrimination experienced in relation to physical appearance and body image (e.g. being treated differently and name-calling by peers and whanau or family members); ethnicity (i.e. being Māori or Pasifika); being gay; being young; or living in a particular socioeconomic area.

Discrimination relating to specific settings

Discrimination experienced within young people's families and whānau, as well as in a school setting, were the most commonly reported and pervasive. However, multiple other sites where discrimination took place were reported by young people across focus groups. Key findings related to the main settings discussed in the research are outlined below.

Schools

School culture was identified as a key contributor, in terms of fostering and permitting discrimination. Participants described a pervasive culture of 'put downs', 'taunts', 'name-calling' and various forms of derision based on a wide range of issues, and indicated that there were few boundaries in high school that operated to stop peer discrimination. Many said that it was often an endemic part of school culture. Indeed, emotional abuse and physical violence from peers, in the context of a normative school culture in which 'bullying' was tolerated, were widely reported across focus groups.

Teachers were identified as having a particular role to play in perpetuating discriminatory abuse within schools. Participants reported a range of ways in which teachers either did not respond appropriately to young people who were the targets of emotional abuse or physical violence, or went so far as to encourage the young person to 'hit back'. Many of the young people reported that teachers also did not respond to requests for help, when the young person was being emotionally and physically abused at school.

For instance, one young woman who had attended a provincial high school recounted how teachers basically, "laugh at it ... they'll say, 'Oh, good job, you probably deserved it'. I've seen that quite a lot and I've had it said to me as well". Equally, teachers were sometimes reluctant to

[27] For some young people this type of abuse continues, as they are either sometimes living in the home of a parent or are in contact with their parent (e.g. due to having grandchildren). Because all participants were over 18 years of age, they were no longer protected by legislation relating to the care and protection of children.

get involved when other students sought help for the person being 'bullied'. It is noted that in one school, the school culture took a strong stance against bullying and most teachers would not tolerate overt abuses towards students. A minority of young people said that they had been encouraged to stand up for themselves, and on one occasion this included being told to 'hit back'. One young person from a family where violence was the norm summed up very clearly how teachers had responded to requests for help at her school:

The biggest thing for me in school is whenever I had a problem ... and I went to a teacher, the teacher would just tell me to deal with it my own way and the only way I knew how ... was to like punch them ... I went to one teacher one day, I think it was Miss [X] and she told me to 'grow some balls'.

Government agencies

Young people reported that they had experienced different forms of discrimination from various government or social service agencies, including the police, youth justice, and CYFS. When discussing these experiences, young people did not always directly link them to their mental health; where appropriate, therefore, these experiences have been summarised (but are not reported in detail) in this document.

Many of the Māori and Pasifika young people in the youth justice focus groups spoke of discrimination they experienced from the police. Several participants spoke of being 'harassed' by 'cops' and treated differently from Pākehā peers, and attributed this difference both to racism and to the fact that they lived in the Porirua area. One-third of participants in the study were also currently in contact with youth justice services, and an unspecified number had also been in youth detention facilities. The young people's accounts of 'juvi' were mixed. Some practices associated with youth detention seemed particularly inhumane:

[W]hen I was in juvi … made me want to go insane, especially when I was in lock up for 23 hours a day, it did my head in … I was … [geographically far] away from my whole family … all alone … my heart dropped when the judge told me I was going to [remote detention location away from whānau].

A significant number of the research participants had been in contact with CYFS at some stage during their lives, due to family violence or child abuse and neglect. However, most did not discuss CYFS or foster care in the context of discrimination or other experiences of unfair and unjust treatment. CYFS was identified as a source of discrimination only for young people who were known to CYFS and who had become parents themselves. One young mother, who was under CYFS care as a child, spoke of the distress she experienced due to discrimination from CYFS:

I suffer from depression and I also had a bit of a drug history … CYFS decided they would take my [child] off me due to allegations of drugs and alcohol, and [they used] depression and stress against me [to say] that I was an unfit mother … I ended up in a psychiatric unit … 'cos I fully lost the plot [following an overdose and having my kids uplifted by CYFS].

Healthcare

A minority of participants spoke of discrimination from staff working in general hospitals and mental health inpatient units. These experiences included psychiatrists not assessing them as people who live within a social context, and not taking a holistic perspective or adequately addressing the impact of trauma on the young person.[28] One young person spoke of the way their psychiatrist assumed a diagnosis that was based on limited information and insufficient assessment time, and that ignored the impacts of the young person's physical health:

They tried diagnosing me as a schizophrenic, because they asked me if I heard voices and stuff and I said 'no, but I hear noises'. They diagnosed me as schizophrenic. [I] went back to the doctors a coupla days later and it turned out my ears were blocked.

Another young woman recalled how she had been spoken to in a derogatory manner by a nurse following an overdose. She was also compared unfavourably with another young person who had also overdosed:

[She said] 'you don't have any problems, there's nothing wrong with you, that girl, she's got problems…' [The nurse did not even] know me … I don't see how that helps someone's illness if people don't take it seriously and make those kinds of judgements. They wouldn't go up to any other patient in the ward that had like a broken leg or had surgery and be like 'your pain is silly', it was just because they were like 'it's mental illness … she did this to herself, therefore we can make a judgement on it'.

Sometimes a young person's distress was dismissed because of their age (i.e. 'they're just young'). Another young woman told of an immensely distressing experience of being locked up inside a psychiatric unit. She regarded compulsory treatment and the practice within inpatient units as discriminatory, and said that it made her 'a lot worse'. When describing the type of discrimination she experienced, she recounted, "[M]edication, [the] lock on the room, lights off. No handles on the door. You don't get anything. They take everything from you so you have nothing."

One young man, who had been seen by a psychotherapist and general hospital doctors, recounted how he had been treated as if he was 'a bloody retard' who was unable to speak for himself: "Rather than speaking to me they were speaking to my mum … most of the questions were about me … [my mum] doesn't know what's going on in my head."

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[28] For example, not adequately assessing the effects of child abuse or of a young person being homeless.

Media

The media was identified by participants across focus groups as having a key role to play in reinforcing discrimination and negative stereotypes, and was seen to feed into the community's knowledge of mental health issues. A young woman from a city focus group commented about the media in the following way:

The media doesn't help, they're very quick to point out if someone who has committed a crime is mentally ill and there's lots of incidents in the media of people going out and doing bad stuff but the occasional time when someone who's really unwell does kill someone, and they make this big deal about 'this person was mentally ill' and it gets really sensationalised and they don't make an effort to say more.

Indeed, across most of the groups, young people spoke of the powerful influence of the media in perpetuating multiple forms of discrimination against young people. The media was regarded as particularly problematic by some for reinforcing and perpetuating myths about mental illness and persistently linking it to crime and violence. Some participants who read women's magazines or watched celebrities on television noted how often the media sensationalised celebrities' experiences of distress. It was regarded as responsible for shaping and reinforcing the public's beliefs about 'mental illness', which were reinforced through popular culture.

Television programmes were also seen as reinforcing negative ideas about mental distress. Collectively, it was believed that the media determines what people regard as 'normal' and what the public understand about mental distress. The media was also identified as a potentially powerful mechanism for creating positive change and young people identified various examples from their own experience (see also the section on the media in Chapter 5).

Chapter Four

Impacts of discrimination

"I just feel like I'm worthless... a no hoper... that there's nothing going for me... [it's] just these things that people say and put into your head" – Participant

Impacts of discrimination on young people

The combination of being singled out for negative treatment within a family or whānau, child abuse, family violence, peer physical and emotional abuse, and overt discrimination over many years, coupled with having no one to talk to or trust, and nowhere safe to be, had significant impacts on the young people's mental health and wellbeing.

Almost all young people who experienced excessive and prolonged abuse at home or school reported feeling intense anger. For many, anger was expressed outwardly, leading to acts of aggression and violence. For others, mental health problems surfaced, leading to depression, and for some, voice hearing. Many of the young people ended up using alcohol and drugs to ease the intensity of emotion arising from the injustice of persistent discriminatory abuse.

Depending on the type of impact (e.g. aggressive behaviour or self-harm) young people often came into contact with CYFS and the youth justice system, or the mental health system, or sometimes both. Approximately one-third of all participants were in contact with the youth justice system and CYFS had been involved in their lives. Approximately two-thirds had been in contact with mental health services, and only a minority of these participants reported having had CYFS or youth justice contact. More often than not, gender and ethnicity seemed to influence the young person's response to the abuse they had experienced, and also the type of service with which the young person came into contact. As mentioned in Chapter Two, most of the young people using youth justice services were young Māori or Pasifika men;[29] whereas the majority of participants who had been in contact with mental health services were young Pākehā women.

The main impacts of discriminatory abuse reported by young people are outlined below. The key areas highlighted included mental health,

[29] Three had limited contact with mental health services while under the jurisdiction of youth justice services. This included counselling, drug counselling and anger management.

aggression and anger, relationships with others and drug use.

Mental health

Young people reported that their mental health had been negatively impacted by the discrimination they had experienced. Several of the research participants reported that discriminatory abuse had led to depression and very low self-esteem. One young woman told how, through her whole life, 'being bullied' had 'led up to having depression and mental illness'. For many, the messages they had received as children both at home and school led to feeling 'worthless', 'a no hoper' and as if 'that there's nothing going for me'. While the young people in the youth justice focus groups did not tend to talk about mental health issues overtly, they spoke of 'going through a phase', feeling 'careless', and being 'really messed up'.

Some people reported that being perceived as having a 'mental illness' created or exacerbated self-doubt, which reinforced negative feelings about mental illness. As one participant said, "It just confirms the thing you fear about yourself ... 'oh my god, people feel that about me, maybe it's true'".

Discriminatory attitudes towards young people from parents had also led to serious mental health issues being dismissed as 'just being a teenager'. One participant who reported having "quite bad depression during my teenage years" said her parents had taken a stance that meant she "was undiagnosed and untreated and it built up to the major episode".

Some participants indicated that they or a close relative had started hearing voices as a result of severe abuses. Voices usually echoed people in the young person's life who had abused them (e.g. parents or step-parents). Some of the young people had used marijuana to cope with the intensity of their feelings prior to voice hearing, and later used marijuana to cope with the intensity of the voices. A minority of young people also reported that they had self-harmed, and two spoke of overdosing. One of the women conveyed the impact of discriminatory abuses in her life in the following way:

I've overdosed [on painkillers] for the last ten years, I can't stop it ... [I do it] to forget everything ... I've been in hospital quite a few times trying to take my own life ... they just let me go straight away ... no one really got down to my problems.

At the age of 13, one of the young men had told his principal during the first year of high school that he wanted to kill himself. This prompted a CYFS notification and the subsequent involvement of child and adolescent mental health services (CAMHS). The help provided by CAMHS included being put in contact with other young people who had similar histories and mental health experiences, and this had turned out to be very positive for this young man and others in the group.

Anger

Participants from across all focus groups reported feeling immense anger as a result of the discriminatory abuse they had endured. Feelings of anger were compounded by not having anyone to talk to or anyone who would help. Moreover, a lack of any emotional outlet intensified anger over time and impacted greatly on their mental health and wellbeing.

Some young people spoke of the way anger had led to 'unwise choices', and acknowledged that anger had negative impacts on their personal lives and relationships. This included venting their anger by damaging property, and behaving aggressively towards peers and sometimes teachers. A young woman who had been passed around several family members, and had been consistently discriminated against within her whānau, told of a violent attack on another student following constant bullying at intermediate school:

I grabbed a pair of scissors ... threw them at a student and they sliced the front of his face ... I tackled him down to the ground ... and I started punching him in the face.

All young people who had been in contact with youth justice services spoke of feeling intense anger and reported acts of aggression towards others (physical, mental, sexual), due to having been persistently abused and treated unfairly over their lives. As one young man said, "that's when I'd smash everything up".

Some participants felt so much anger about the abuses they experienced, and inaction from teachers, that they behaved aggressively. One young man had been referred to mental health services for 'anger management at the age of six years old'. He experienced learning difficulties and was subjected to daily abuse at school.

He reported that his anger towards teachers had compelled him to leave school before he committed further violence:

I left school when I was 16. I decided that I was out of there before I knock over more teachers. I punched Mr [X] over the desk. Knocked him on his arse. I told Miss [X] ... I was slow at writing and when I looked up she had rubbed off all the stuff I was writing down, rubbed it off and started writing new stuff and she said 'Oh you have to come back at lunch' so I went off at her. Went off my nut at her. So I went to see the principal and like [another participant] was saying that she got stood down.

It is interesting to note that many young people said that much of the aggression they displayed when they were younger was now better managed. For some, having left school, and being

independent and away from parents or families, had reduced feelings of anger:

I went through a phase where I was real fucked up ... I didn't talk to anyone ... now it's all good ... I had to handle that shit better, don't get angry as much [now] ... because now I can look after myself, my parents were pricks.

Relationships with others

Due to experiences of discriminatory abuse, some young people said they no longer trusted others, and some avoided contact with other people for fear of 'being hurt again', or fear of the consequences of people knowing they had a mental health problem. Others who were known to have mental health problems said they were afraid of being 'judged' by teachers and school authorities. One young woman had learnt at a young age that disclosing mental health problems could lead to overt discrimination from a private school and the threat of being excluded or expelled:

Fear about being judged differently for having a mental illness and it's something that I tried to keep as much a secret as I could ... [the threat] confirmed that I needed to keep it a secret.

Discrimination specific to mental health issues had the potential to impact on new relationships and friendships. A minority of participants said they felt afraid of disclosing mental health issues to a new partner or friend for fear of how they would respond, or anticipatory fear based on previous experiences of disclosure:

[Discrimination] impacts on relationships and building relationships because you feel like 'I've got something to hide' and how is someone going to react ... people do have negative ideas about someone with a mental illness. I was really worried when I met my partner ... and ... what his family was going to say ... people have reacted when I've been really unwell and they haven't understood ... it gives a lot of self-doubt relationship wise.

Several participants in the research indicated that experiences of abuse and discrimination had led to depression, voice hearing, alcohol and drug use, overeating and other mental health or behavioural issues that affected the development of friendships. As noted previously, however, contact with other young people through the CAMHS service had enabled particularly isolated young people to make significant friendships. In some groups, friends were clearly an integral part of the day-to-day lives of the young people and were like 'family'.

Family and whānau relationships also sometimes remained a source of sadness and bitterness for many of the young people. While trying to lead more positive and constructive lives, several spoke of having to remove themselves from the family situation. Some said they minimised contact with a parent or parents who remained hostile, emotionally and physically abusive, drank to excess or took drugs, and in other ways adversely impacted on the young person's mental health.

Drug use

A clear message from the young people was that the cumulative experience of discriminatory abuse often led to alcohol or drug use to 'escape' the emotional pain resulting from abusive lives. A young woman whose parents were abusive, and also heavy drinkers, spoke of drinking excessive amounts of alcohol and turning to 'heavy drugs' to 'ease the pain' and 'feel better' about herself. She had since stopped drinking or taking heavy drugs as she tried to get her life on track.

Chapter Five

Strategies to reduce discrimination

Listen to us
Don't judge
Open your eyes

Strategies to reduce discrimination

The spectrum of strategies

Participants identified a range of strategies to reduce discrimination. The diversity of strategies proposed spanned a spectrum from the macro-systemic, to community, to large and small institutions, social networks and the individual level.

Figure 1 presents a socioecological model, which provides a useful framework for grouping ideas and themes from the data (Dalton, Elias, & Wandersman, 2001). It also provides a structure for conceptualising and implementing potential strategies to reduce discrimination. This model of analysis describes the various systems and social relationships within which young people are located. Consistent with the findings from the research, the model recognises that young people function within interconnected systems and social structures, and can be understood only within a broad, interlinked and dynamic social context. The framework provides an analytical tool for identifying the multiple levels at which discrimination operates, and allows identification of multiple strategies relevant to each sphere. While recognising the need for individual change, this model recognises the importance of systemic change across multiple dimensions of society.

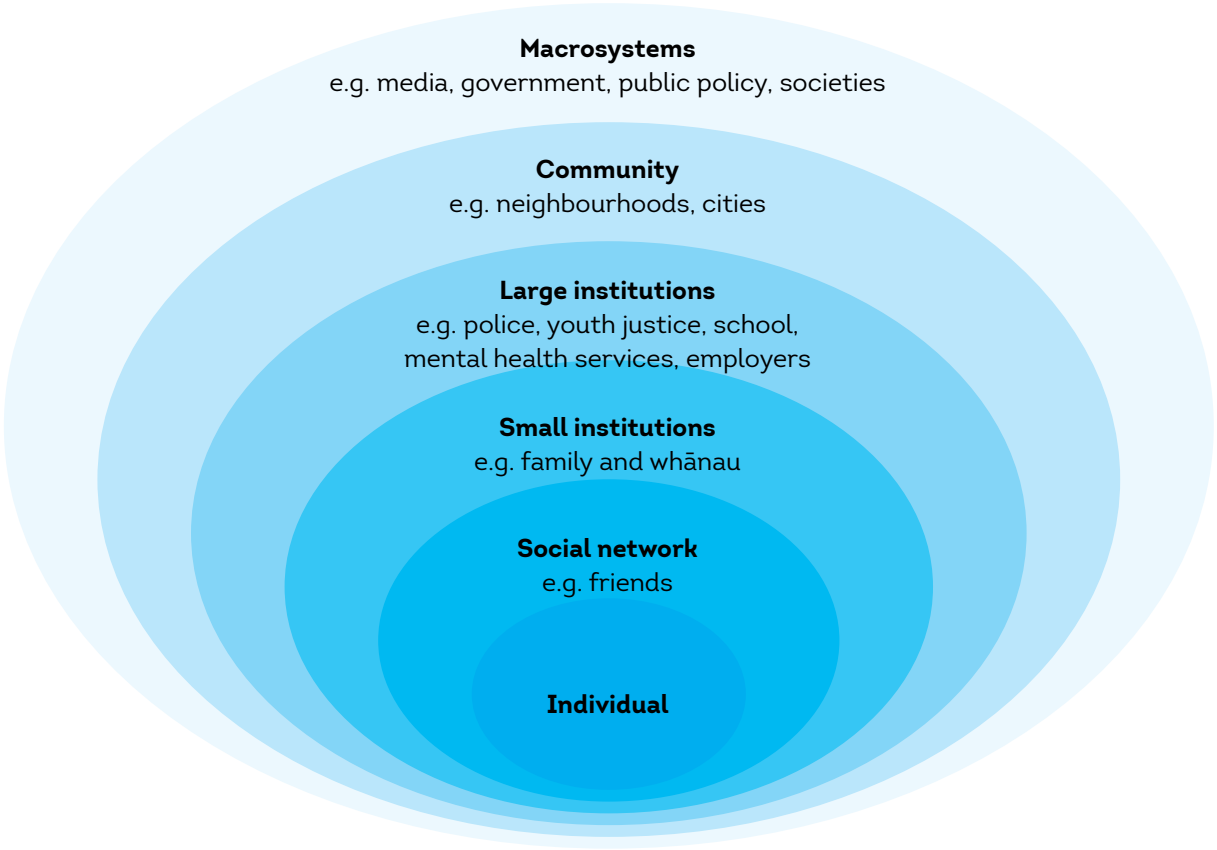
A socioecological model is consistent with the Like Minds, Like Mine Plan, which seeks change across all three dimensions: organisational, institutional and individual. As shown in Figure 1, we have adapted the socioecological model to better reflect the findings of the current research, in which families or whānau are identified as a key site for change. The family and whānau are state-sanctioned institutions accorded unique rights and responsibilities. They are central to shaping 'normative' culture and are also shaped by dominant cultural norms. The findings of this research show that the family and whānau can be responsible for perpetuating discrimination and discriminatory abuse, and normalising the abuse of children and young people.

In the socioecological model (Dalton et al., 2001), the family is conceptualised at the level of

'social networks'. Given the institutional status of families and whānau, and the power invested in families to care for, protect and control children, we instead refer to the family or whānau as a 'small institution'. We have separated the family and whānau from larger institutions, such as schools, youth justice services and mental health services, in recognition that the latter are larger institutional structures with particular legal and regulatory powers that differ from those of the family and whānau.

Participants who had a political interest in human rights issues, or were actively involved in groups or organisations to reduce discrimination, identified a range of strategies that have the potential to leverage positive change across all levels of the socioecological model. Participants across all groups were cognisant of ways in which discriminatory attitudes, behaviours and practices could be changed, and they conveyed these ideas in both direct and less direct ways.

Figure 1. A socioecological model of analysis



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Macro-systems

Several young people commented on politicians' influence in making positive changes for young people. This was particularly so in relation to ensuring that young people have opportunities to engage in meaningful and affordable education and training, and to gain employment that ensures a living wage.

Some participants spoke of the power and effectiveness of politicians' speeches, their championing of mental health issues, and their work to prevent and reduce all forms of discrimination and abuse towards young people. As one young person said, "I think people need to hear those speeches, not just at conferences, they need to hear politicians really care about what they're doing". Another young woman cited support and a personal connection with an 'important' person, such as the Right Honourable Tariana Turia, as having a significant impact on young people:

[W]ith Tariana, when she heard about us losing funding for supportive employment for young people with mental illness she tried to do something about it. [We met and] went to her office at parliament. Some of the clients who had used the service [came] and [Tariana] heard their stories about getting back into employment and was really positive about it. It was really cool to have someone important listen.

Some participants indicated that having public figures, such as 'John Keys [sic]', talk openly about mental health issues would be an effective way of normalising the issues.

At the end of the focus groups, facilitators asked the young people what they would like to say to politicians if they had the opportunity. The following responses capture the sentiments of a range of participants: 'listen', 'don't' judge', 'listen to what's been happening [to us]', 'don't judge a book by its cover', and 'give youth a chance'.

Media

The media was identified as a potentially powerful mechanism for creating positive change in the way young people, including young people who experience mental health issues, are portrayed in the media.

Few participants were aware of the current Like Minds, Like Mine advertising campaign, 'Be There, Stay Involved', which specifically targets young people and their friends. However, one participant who knew of the advertisements noted that this was an effective way to convey how to respond to friends with mental health issues. She commented, "this is my friend, he has mental health issues, and this is how I treat him … so that people get the idea that's the way people with mental health issues should be treated".

However, another participant who knew of some of the current Like Minds, Like Mine advertisements commented that they, "needed to have an actual real life young person, not someone who's kinda young 'cause they're in their 30s, but someone who's actually young on the ads … I think that's one thing that could make a big difference".

Some participants suggested there was a need for 'normal, everyday people' to get across the idea that 'people with mental health issues are just people too, and to treat them like everybody else'. Other participants reiterated this sentiment by again referring to the power of the media to promote positive messages across communities, including the idea that 'I am a person and I have a mental health issue'.

A resounding theme across groups was that the 'John Kirwan adverts' were well known and had a significant impact on raising awareness and changing attitudes about mental health issues. As one participant said, "The All Black [advert], John Kirwan, that's a big one and I think it's one that's definitely helped a lot, this manly All Black talking about that sort of stuff and his website is absolutely amazing". Similarly, another young person commented that these ads had conveyed the idea that, "you can be a tough guy, Kiwi bloke and experience mental illness at the same time. They're not things that are contradictory to each other, they're things that can be experienced at the same time". As yet another participant commented, "he's definitely broken the stereotype".

The anti-smoking advertising was well known across focus groups and had clearly engaged young people. Many participants commented that this campaign was successful in creating a culture where smoking was no longer 'fashionable'. As one participant commented, "the way they've done the anti-smoking as where it's like, 'nah man, it's not cool to smoke, I wouldn't want to date a smoker' – it's made the message cool, they've younged it up … 'cause it's aimed at young people." This participant suggested that the same approach could be taken in relation to mental health issues and noted, "there are some really cool New Zealanders that have had mental health stuff, like Antonia Prebble from Outrageous Fortune, she was on the Lowdown website, she's someone who's cool and young".

Another participant who indicated that advertising did not need to focus on mental health issues, but rather a more accepting society, commented, "it'd be cool seeing TK from Shortland Street just chilling out with someone at Head Space[30] or something". Advertisements "just questioning people … why aren't they empathetic, why aren't they thinking about others" were also suggested. Participants suggested 'putting out a challenge' along the lines of: 'I support people, what do you do to support people?' or 'What will you do when the cards are down?'

Reporting and advertising were both regarded as key sites for change, as was the need for 'responsible reporting' and policies that govern the way young people and people who experience mental health issues are portrayed in the media. As a young woman commented, "they're not allowed to talk about suicide so there should be something [like that for young people and mental health issues]". Some young people suggested the need for a regulatory body to oversee appropriate standards, so that myths and

[30] A youth respite service.

stereotypes were not permissible in any form of media.

Public education
Public education was discussed by young people as one of the most important strategies to reduce discrimination of all kinds. This applied to policies and practices, both at the macro level and at the institutional and community levels of the socioecological model. A lack of education was identified as a key contributor to discrimination associated with mental health issues, as well as discrimination associated with being young, a member of a marginalised ethnic group, being gay and other kinds of difference.

A young person commented that public education needs to, "open up a lot of paths for people to try and understand and also break down [the knowledge about mental health issues and discrimination towards young people] for someone to understand … not understanding something can be difficult to open up to".

A young woman from the rainbow group suggested having, "mental health awareness days where you actually get mental health consumers to set up stalls … [or] workshops that people from the public can go to … [where there are] … fun things and also lots of information, videos".

Pamphlets described as similar to those distributed by Skylight, but 'not that lame', that focus on 'what to do if your friend has mental illness', were suggested as a way to help people learn more about how to help friends who experience mental health issues.

Community
As mentioned previously, public education was regarded as one of the most important ways to raise awareness of discrimination in relation to mental health issues and negative stereotypes about young people across communities. Raising awareness was regarded as a key way to reduce these forms of discrimination and to foster inclusive societies. Communities 'being active and vocal' and 'pull[ing] together as one' to stop discriminating, and to promote awareness of discrimination, were identified as essential to creating positive change. Several participants spoke of how 'judgmental' the community is, and of the need to make it 'fashionable' to 'be loving, open and non-judgmental'. One participant likened this to the way the anti-smoking campaign had created a community where smoking is now unfashionable and not 'cool'.

Public seminars that address 'mental health … [and] … how you should treat people with mental health issues' and 'how to react' were also thought to be a useful way to educate communities.

Having 'contact with people who are mentally ill' to better understand people's experiences of mental distress was also mentioned as a way communities could educate themselves, while also reducing 'alienation' amongst people who experience mental health issues.[31]

The use of wristbands appealed to young people as a way to promote messages of support across communities, as it had done in Christchurch following the series of earthquakes. As one of the participants commented, "I think it would be really cool to be like 'I'm an All Black and I wear a wristband to show I support young people with mental illness' – I'd totally wear a wristband for that and I wouldn't wear if for anything usually".

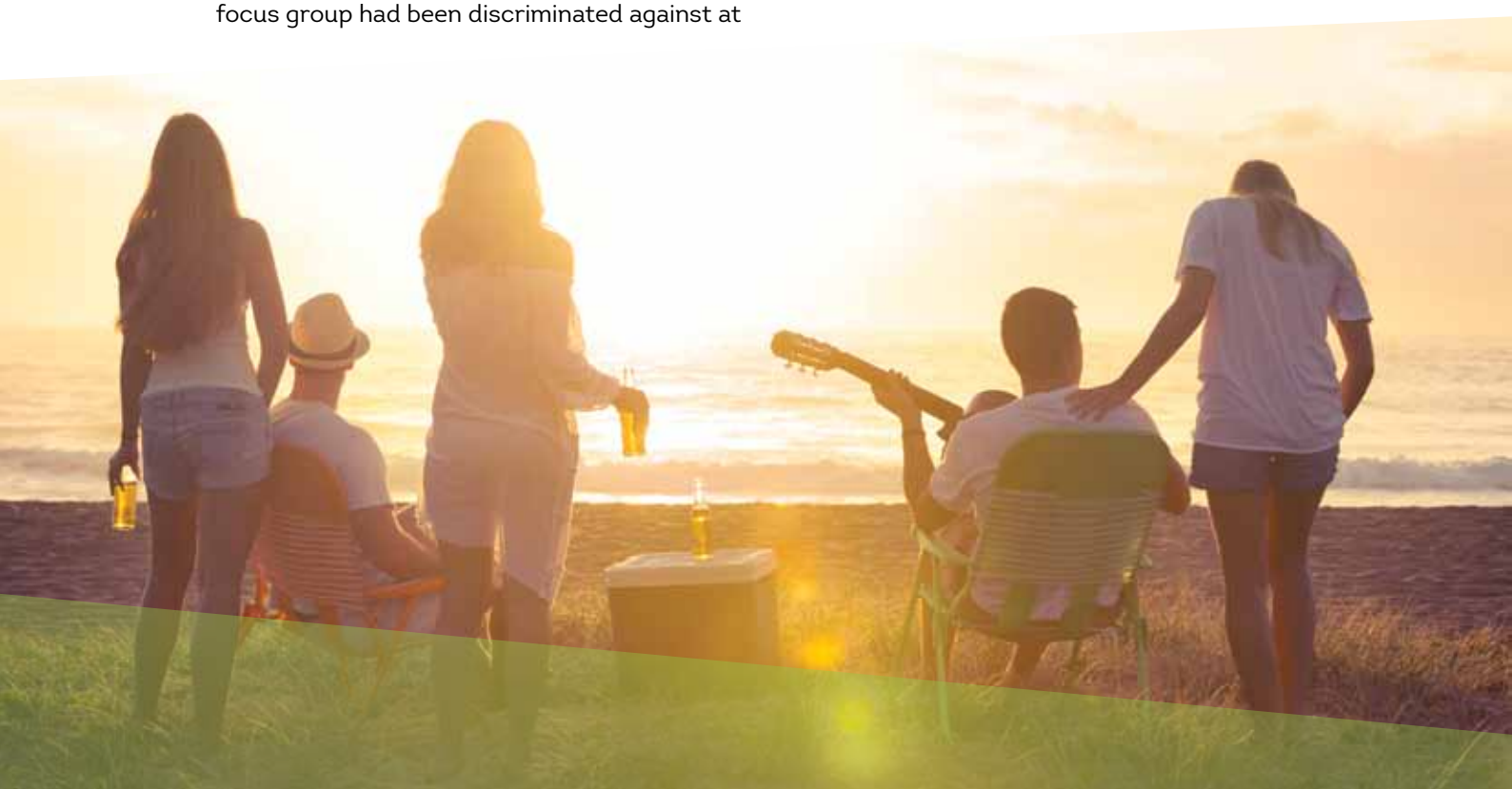
Large institutions
Participants identified a range of large institutions that could be targeted for change, in terms of raising awareness and improving knowledge of mental health issues and discrimination towards young people. The police, mental health services and employers were identified as key change makers at an institutional level. Youth justice services were identified by participants in a positive way, in terms of the assistance some of the young people had received from individual staff.

[31] The Mental Health Foundation and the Like Minds, Like Mine programme have fact sheets of this kind, but these were not spoken about by participants. There are a range of possible reasons for this, such as it could mean that young people do not access places where this information is provided, or that the format of delivery of these resources does not appeal to young people and therefore goes unnoticed.

Police
As reported in Chapter Three, the police were identified as a source of discrimination amongst rangatahi. Few strategies were identified, in terms of promoting education about mental health issues and reducing discrimination towards Māori and Pasifika young people, for use amongst the police. However, one participant suggested that when police visit schools, they need to dress in 'casual gear' and avoid wearing a uniform, because, "it really intimidates young people and triggers us into thinking 'yeah blah blah blah you did this [negative thing] to me last weekend, whatever'". The participant suggested that police need to convey to young people that the police are people too who 'have feelings'.

Mental health and physical health services
Participants from a provincial focus group identified ways in which a child and adolescent mental health service (CAMHS) had effectively engaged young people to promote education about mental health issues, to 'normalise' the young people's experiences, and to reduce discrimination between peers. As one participant explained, "[We] met at child and adolescent mental health. They actually got us to communicate with the others … and now we've got this thing called the CAMHS groups and we do heaps of activities together to keep us all connected". All of the young people in this focus group had been discriminated against at school, so the service provided not only a safe place, but a place where "there are a whole heap of other children with mental health [issues] … for us all to connect", and this was "one good way for us to be, because at least we felt how other people felt and not thinking it's just us". Another young person commented, "you can feel welcome … and no one discriminates or bullies or anything like that … we actually feel that we're wanted there because there is so many of us that have got something wrong with us, but we can manage to keep it together as one big group". The importance of making friends through the services offered by CAMHS was further commented on by another person in this focus group: "all of us are like friends there".

Participants in a city focus group spoke of the need for staff in services to take more time during assessment. As one young person commented, "I'd rather wait longer and have a proper check over than be in there five minutes [with them] going 'Yup, you got this … see you later' … most of the time they just hand me out all these pills". Holistic assessment and the use of non-medical interventions was regarded as something that could be advocated as part of broader strategies to promote a contextual understanding of mental health issues, and an understanding of young people in their social and cultural worlds.



Employers
Workplace education for employers and employees was identified as a key strategy to improve knowledge about discrimination and mental health issues. Several young people indicated that they had been employed by 'supportive' bosses who actively worked against discrimination, and who had shared experiences and disclosed their own mental health issues. This approach was regarded as empowering and helped the young person to feel less fearful and alienated at work. One young woman spoke of her father's role as a manager and his influence in disclosing his own struggles with mental health issues:

[M]y dad has taken it upon himself to try to educate people about mental illness, he's a manager of staff and if staff come to him and say their family is having personal difficulties, he uses himself and his own depression as an example and kind of discloses it ... and has my permission to disclose my mental illness to normalise it. I think it's good practice.

Courses for employers and employees were also identified as an effective way to educate people about discrimination and mental health issues. One young person commented, "I think it would be awesome if there was government funding for workplaces to send managers on courses dealing with people with mental health stuff". They suggested that this approach was needed in places such as large retail or fast food outlets that employ many young people and where managers sometimes, "don't know how to deal with [staff and customers who experience mental health issues] and are quite negative". One young woman commented, "I know I would feel a lot more comfortable speaking with people at my work if they just had that education because I know a lot of them don't".

Youth justice services
Participants who were in contact with youth justice services commented on ways that individual staff employed in services provided exercises and practical strategies to cope with anger and distressing emotions. While this content is not applicable to strategies aimed at reducing discrimination, it is important in terms of identifying ways in which youth justice and other institutions can proactively help young people manage distress. Equally, it highlighted the personal factors that let young people know they were cared about and that someone took an interest in them. One young man spoke of, "guards (Pākehā, Māori and Samoan) that helped me out ... noticed that I was angry and shit and gave me these exercises to do ... used to train me in the morning when I woke up and before I went to bed. That mellowed me out a bit". Another young man commented that the "Islanders staff ... helped me out with some stuff".

Small institutions

Families and whānau, peers and schools were identified as the most commonly reported sources of discrimination and abuse experienced by young people in this research. This may be largely because these are the most common context or environment for young people most of the time, and so are a major source of influence. Although there was considerable discussion about abuses that occurred in these particular contexts, few strategies to reduce discrimination in these settings were identified by participants. It is likely that the systemic nature of families, whānau and schools, and the powerlessness that the young people felt in these contexts, made it difficult to easily identify solutions or strategies. However, the participants had some ideas and feedback about what could have alleviated their experiences of discriminatory abuse and helped when they developed mental health issues.

Families and whānau
Participants spoke strongly of the need to be able to communicate within the family or whanau, and for adults to listen to young people.[32] The longing amongst the young people to be able to talk openly within families

[32] Although outside the scope of this research study, many had lived with parents who abused alcohol and drugs, so this was also a focus for remedial action.

and whānau, and to be able to talk to parents or parent figures and seek their support, was overt. One young person who had experienced considerable discrimination within her family put it this way:

To actually sit down and have a family talk about it, without any problems, without any alcohol. Just calm. And listen to what one person has to say and then see if there is another problem, not just 'what have you got to say or that's all right, that's okay'. We didn't get family talks [when I was little] and back then I wish we did 'cos I wouldn't have turned out the way I did in leaving home … So yeah, that's pretty much all I used to want, to go home and have a family talk but it never happened.

Another participant indicated that there was also a need for privacy when young people do talk to their parent/s or parent figures:

I'd like to sit there with my family and just … have a talk … [but] they'll go drinking and the next minute instead of it staying private, they take it to everybody else and then they become involved and then we have to deal with everyone 'cos you know, they bring it up and what not.

A young man whose parents had kicked him out of home when he was diagnosed with a mental health disorder had since benefited from a father who had started 'to actually listen'. He commented, "[my dad is now] … always checking out 'are you ok' … since he actually took the time to listen, he's more courteous".

Sadly, several young people spoke of how they would have liked 'love, support … understanding [and] respect' from their families and whānau. Some spoke of what they would be like with their own children in terms of 'teaching them heaps of cool stuff', 'treat[ing] them differently to what you got treated' and 'giving them more opportunities'. As one young man put it, '[I'd] treat them way better than what I had'.

Pamphlets and brochures were recommended as useful ways to convey information about mental health issues. However, the young people also wanted to know where to go to get support for mental health issues (e.g. 'the Mental Health Foundation'), and did not think this information was readily available. This suggests the need for an approach to mental health promotion and literacy that is designed in a suitable way for young people.

One participant commented that families need to, "be involved, stay involved and stand up for their family member in a positive way". She also suggested encouraging families to be open about discrimination and mental health issues and to discuss them in a positive way, and for families to champion these issues by educating others. Ideally, families needed to be encouraged to, "stay involved and not be scared … [and make] that transition from being further away to being part of it … you begin to understand your family member".

The general sentiment from young people was that, "families need to be there, they need to be the support network, they need to be alongside the other person to allow a person to feel like they're not gonna be discriminated against … [that] they can just ask [the family] for help if they need it".

Another participant who experienced mental health issues said there was great potential for, "encouraging families to be a champion for their family member and stand up for them in positive ways … [it] helps in so many different ways and does stop the discrimination". This participant described how her sister had been an active champion in terms of educating others:

She would educate them on the reality of what I was going through and so it kind of has that double thing of helping people to understand where I was at and not discriminate against me due to misinformed ideas, and it made me feel good because someone from my family was defending me.

Church was also identified as a potentially powerful place for education about mental health issues:

My church is like my family, so we're having cool times of education at the moment with mental illnesses, they're awesome with this so I think educating [and] opening up discussion about how we can help people with mental illness … is really important.

Schools and peers[33]

The school setting was also identified as a potentially powerful place to reduce discrimination. As one young woman said, "schools play a big part [in conveying messages about discrimination] because they have a captive audience and so much discrimination comes from peers … having stuff sorted with your peers would be really good". A young woman from a particularly progressive city school spoke of teachers who proactively countered discrimination and censured young people who engaged in bullying. In this way the teachers' influence meant it was unacceptable to discriminate and this had impacted positively on the general school culture.

A key strategy that participants recommended was to create positive change in what is regarded as normative school culture. Many participants spoke of the need to create an environment where it is not 'cool' to be discriminatory or exclusive, or to verbally or physically abuse peers. Connected to this was the suggestion to make it 'fashionable' to have diverse friends and to be 'open' to others from diverse backgrounds. Drawing on the 'public education' approach, participants spoke of the need for education about all forms of discrimination across schools from a very young age.

Many participants indicated a need for school-wide education about the impacts of mental health issues and discrimination. They recommended including this as part of the standard school curriculum, starting at primary school and continuing through to secondary school. Having contact with people who experience mental health issues was widely identified as a key strategy to foster greater awareness and inclusivity. However, some participants spoke of the need for appropriate education and the need for speakers who come to schools to be more suited to the student audience. As one participant commented:

[M]y school had the Like Minds, Like Mine thing, they had two people who suffered from mental illnesses that came in and showed us all the adverts, but the problem was these two people [were] completely scary as. One [person] was completely gothic which I'm generally okay with, but I noticed a lot of people were trying to keep as far away from [the speaker] as possible because of [their] quite intimidating clothing.

There is some irony in this, and it is worthy of consideration in regard to the understanding and acceptance of diversity by young people.

The other speaker was described as "an old woman in her late 40s didn't look like she took care of herself, she was quite large and bad hair … and was telling us about all these people she sees and voices she hears and it was all … so damn overwhelming'. In contrast, another participant commented on Like Minds, Like Mine speakers who go into schools being, "real and down to earth and easy to identify with", and said that:

Meeting people like that has helped me not to discriminate against other people and not discriminate against myself. I think if that person's okay then I'm okay … that person doesn't come across as 'nuts' or 'crazy' … so maybe I don't come across like that … learning from actual people and having the opportunity to meet people who are different has really made a difference.

Someone else who had listened to Like Minds, Like Mine speakers suggested the need for more attention on issues such as depression, which

[33] The socioecological model typically separates institutions (such as schools), and social systems (such as peers). Given participants' focus on emotional abuse and physical violence from peers within the school environment, we have conflated schools and peers under 'small institutions' in this report.

Although outside the scope of this report, it is important to note that young people also supported school-wide education in relation to the impacts of child abuse, family violence, and abuse from (or between) peers at school.

many young people experience, and to also include stories about wellness and recovery from mental illness. Another participant suggested using more interactive, storytelling approaches to engage students about discrimination per se:

Write it on the board, 'discrimination' and ask what is this to you guys? Do you guys have any feelings [about it]? Do you guys have any stories about discrimination? Have you seen it in the community … break it down … tell stories about how we've prevented this from happening.

Similarly, the need for teachers and other staff working within schools to be adequately trained was commented upon. A very clear message from participants was that teachers need to listen when young people seek help, and to model inclusivity and positive ways of relating to people. The need for teachers to have an increased understanding of mental health issues was also highlighted. One participant reported that a teacher 'knew what was going on' and had therefore been 'more understanding' when the young person experienced mental health issues. School guidelines were recommended as a way for staff working in schools to better understand mental health issues and to know how to support young people experiencing mental distress.

Many participants spoke of the importance of the 'accept them as them' approach, so that everyone is included, irrespective of mental health status (as well as ethnicity and other social characteristics). The establishment of 'diversity' or 'peer' clubs in schools was recommended as an approach to foster great inclusiveness.

Social networks

Friendships were highly important to research participants. However, it was rare for participants to talk of social networks beyond the school context. Some participants spoke of being 'lucky', with good friendships and a camaraderie amongst peers, now that they were no longer at school. For example, the youth justice rangatahi spoke of how their friends within services had become like family. Issues relating to peers were also highly important for young people who struggled to make friends or to sustain friendships over time, or had lost friends due to becoming the target of bullying at school, or because of the negative impacts of mental health issues on relationships.

As reported in the context of schools, a key message from young people was the importance of having 'diverse friends' and being proactive about being inclusive of people from diverse social backgrounds. The prevalence of unhappy and unsafe families and whānau made the young people's social networks all the more important.

The individual

While people are shaped by their relationships within a social context, they also have agency to influence their own lives and the lives of others at multiple ecological levels. Participants in this research made commendable efforts to address multiple forms of discrimination. Many of the young people in the focus groups spoke of how their experience of being discriminated against provided insights about their own discriminatory attitudes towards others. These largely cohere around having contact with people who experience mental health issues or who are from diverse social backgrounds, and gaining a better understanding of the impact of life adversities on young people's mental health:

[B]eing discriminated against myself, I discriminate against other people less … [and] realising that everyone is different … but I used to be judgemental about … stupid things like what [people] wore. Now I look at each person as an individual and if they're doing something 'weird', I don't put any judgement on them … [also] getting to know more people who have stuff that has gone wrong in their lives … mental health stuff, seeing that they're all different people and are accepting of the people around them, it kinda supports my idea that people discriminate less if they've gone through something really hard themselves.

The experience of being discriminated against, combined with having friends and therefore being in contact with people from diverse social backgrounds, led to less fear of difference and greater awareness and acceptance of others:

I think [my experience of discrimination] makes me more conscious of what I'm saying and how I'm reacting to other people. And I think having friends who are … black … gay … transgender, it helps you to … feel less discriminatory towards other people because you understand better, and people are always scared of what they don't understand.

Being exposed to positive role models, especially parents who responded positively to discrimination that they experienced, provided one young woman with a way to cope with discrimination related to mental health issues. A few young people spoke of being aware that they had discriminated against 'the discriminator' in their attempts to change the discriminatory behaviour of others.

Some participants talked about the various ways they had coped with discrimination and had actively tried to address it amongst their peers. One young woman described how she tried to create an inclusive environment in her school:

In my group … we actually are an international group from all over the world and we play basketball … we don't discriminate against each other because we all get on really really well and we're always welcome to bring in somebody else … me and my boyfriend were like 'hey let's play some basketball' and then we asked some people if they wanted to play basketball and they were like 'yeah' … and we were all from different ethnicities … it brings people together and [means] making friends as well. It's really cool.

Actions like these, that young people can carry out to address discrimination in their own social settings, are one way to ensure strategies are relevant for other young people.

Overall, what young people said they would personally value most is having a parent, teacher or other significant adult to actively listen to them, to take their concerns and worries seriously, and to provide help.

Chapter Six

Discussion

"History will judge us by the difference we make in the everyday lives of children" – Nelson Mandela

Discussion

The aims of the research were to explore the impact of discrimination associated with mental health issues from the perspective of young people and to better understand the relationship between young people's experiences of discrimination and mental health issues. The research was based on the premise that young people's experiences of discrimination associated with mental health issues differ from adults, due to the particular social location young people occupy in society, their life stage, and the tasks and responsibilities associated with entering young adulthood.

Contextual understanding of discrimination

The findings from the study indicate that young people conceptualise discrimination in a multi-dimensional, rather than a uni-dimensional, manner. During focus group discussions, participants were asked explicitly about discrimination in relation to mental health issues. However, most participants spoke of discrimination relating to diverse issues, reflecting a multi-dimensional conceptualisation of discrimination. For example, most of the labels and name-calling the young people reported had little to do with mental health status. This finding differs from the Mental Health Foundation's previous discrimination research project, where most of the adult participants reported labels and name calling specific to mental health status (Barnett & Barnes, 2010).

Indeed, young people's experiences of discrimination were often understood as injustices that involved being targeted for adverse treatment in a number of ways. For example, childhood abuse, family violence, and having parents with alcohol or drug problems were common experiences, with young people the target of discrimination within the family or whānau. Peer-aged bullying was also a

dominant theme, with emotional and physical violence occurring at primary and secondary school, and in the public domain. This was related to a number of issues, including being considered different in some way, due to physical appearance or mental health status.

Being singled out for adverse treatment was common across groups, and the young people's accounts of discrimination also cohered around the following: ethnicity, being young, having a history of contact with CYFS, being involved with youth justice services, being known to police, being lesbian, having no school qualifications and being unable to secure employment. Irrespective of the perceived reason for discrimination, these experiences had often resulted in social isolation, created a barrier to young people's participation in the school environment, and meant the young people often left school at a young age. As noted previously, the term discriminatory abuse is used more accurately to capture the severity of the young people's experiences of discrimination.

It is important to acknowledge that family violence is a significant social problem in Aotearoa New Zealand (Fanslow, 2005), and has been linked to poor mental health and social outcomes during adolescence (Harold, 2011; Repetti, Taylor, & Seeman, 2002). Moreover, the relationship between child abuse and family violence, and subsequent psychological problems amongst young people, is well documented (Goodwin, Fergusson, & Horwood, 2004; Flood & Fergus, 2008; Harold, 2011; Lievore & Mayhew, 2007; World Health Organization, 2006). Research also indicates that emotional abuse and physical violence – referred to as 'bullying' in popular culture – is highly prevalent amongst young people in New Zealand schools (Adolescent Health Research Group, 2008). The psychological impacts of emotional abuse and physical violence from peers are significant, and often result in anxiety, stress, shame, depression, anger and insecurity (Egan-Bitran, 2010). As noted, bullying and other forms of social exclusion often occur in the broader context of child abuse, family violence and poverty (Carroll-Lind, 2009; Fanslow, 2005; Ridge, 2009).

While outside the scope of this study, all of these dimensions were integral to the young people's discussions of discrimination associated with mental health issues and created significant barriers to young people's social inclusion. A very clear message was that being singled out and subject to multiple forms of discrimination, especially in the home and school, had serious impacts on young people's mental health, often led to poor social outcomes, and for some, had at least temporarily limited their opportunities in life.

Impacts of discrimination

In relation to the second research aim, the young people clearly articulated the adverse impacts their experiences of discrimination had on their mental health. Many participants indicated that this had led to multiple psychological and social consequences. For example, depression was commonly reported, and some participants used drugs and alcohol to 'numb' emotional pain arising from discrimination. Other reported impacts included self-harm, overdosing, intense anger, and a lack of trust in family or other relationships. It is clear that participants require a trustworthy or respectful adult to provide a safe space, within which they can have an emotional outlet for their experiences of discrimination.

The psychological and social impacts of discriminatory abuse reported by young people in this research echo other work in which violence in the family, whānau or school has been documented (Egan-Bitran, 2010; Repetti et al., 2002; Fanslow, 2005). In this research, the young people's accounts especially illustrate the long-lasting impacts of emotional abuse. This form of abuse is reported, in child abuse statistics, to be the most common in New Zealand (Families Commission, 2009).

Reducing discrimination

The young people in this research identified a range of strategies to counter discrimination. Some of the strategies suggested are already in place, or readily lend themselves to the Like Minds, Like Mine programme such as: working with the media to promote positive messages about mental health and young people; working with and supporting large institutions such as employers, the police, mental health and health services, and youth justice services to address discrimination towards young people and young people who experience mental health issues; and, working more generally across communities to provide public education about mental health issues and discrimination in ways that reflect young people's experiences. Some participants suggested peer-initiated strategies, such as creating diversity groups at school or establishing diversity inclusive sports.

However, there is a need to be more responsive to young people's conceptualisation and experience of discrimination, so that Like Minds, Like Mine work reaches and adequately captures the interest of this particular population group, especially Māori and Pasifika. Likewise, strategies need to be promoted that can be effectively used by organisations and those who have the power to influence young people's lives (e.g. policy-makers, school principals, teacher training educators, Whānau Ora providers). A conceptual framework also needs to be developed that is dynamic, and builds understanding of the ways discrimination contributes to the development of mental health issues and exacerbates existing mental health issues.

A more general cluster of ideas proposed by the young people reflects a shared desire for a cultural shift in the way children and young people are treated, especially within families, whānau and school. The Like Minds, Like Mine programme focuses specifically on mental health issues. However, if work to reduce discrimination is to achieve expected outcomes in relation to young people, there is a need to address the multi-dimensional nature of discrimination, and to more closely address power dynamics, relationships and communication. This is especially so within families, whānau and schools.

Facilitating institutional change of this nature is an ambitious undertaking. However, there is potential for the Like Minds, Like Mine programme to influence broad social policies that impact on the lives of children and young people. The Like Minds, Like Mine programme is also in a position to further develop the recommendations of the Mental Health Foundation's previous research, which explored discrimination within and towards families and whānau (Barnett & Barnes, 2010). Earlier recommendations focused on raising awareness of the way people relate to one another, the power dynamics that operate in different social contexts and the importance of effective communication (Barnett & Barnes, 2010).

The '5 Ds' approach (i.e. speaking or behaving in ways that are derogatory, disrespectful, dismissive, demeaning or degrading) is one potential strategy for raising awareness of discrimination. The 5 Ds approach offers a framework for better recognising and understanding discrimination, and realising the impacts of discrimination on young people. This model could be adapted in creative and engaging ways, for work with young people in schools and

for use by organisations working with families and whānau.

The potential of this approach would need further exploration with young people, as the evidence is that the solutions for youth work best when youth are part of the development. In addition, the opposite of the 5 Ds (i.e. speaking and behaving in ways that are complimentary, respectful, caring, uplifting and empowering) could be usefully deployed as examples of healthy ways of communicating with one another across diverse social contexts.

Figure 2 provides some key prompts for promoting awareness of relationships, power dynamics and communication.

Figure 2. Relationships, power dynamics and communication

- ✓ Awareness or balance of power
- ✓ Positive talk
- ✓ Listening
- ✓ Owning our own feelings
- ✓ Validating different experiences and worldviews
- ✓ Expressing warmth
- ✓ Communicate respectfully

By embedding a specific focus on relationships, power dynamics and communication within the family, whānau and schools in Like Minds, Like Mine work, while also promoting education about mental health issues and discrimination across schools and communities, there is significant potential to achieve change that is both effective in reducing discrimination and improving the mental health of all young people.

More generally, the principles of Whānau Ora can be utilised by the Like Minds, Like Mine programme to address discriminatory abuse within families, whānau and schools. The principles of Whānau Ora are applicable to people of all ethnicities, and to diverse family types, social relationships and institutional contexts. Whānau Ora has universal relevance and provides a framework to address discrimination that is relevant across diverse social systems.

Figure 3 presents an outline of the core principles of Whānau Ora (Durie, Cooper, Grennell, Snively, & Tuaine, 2010).

Figure 3. Core principles of Whānau Ora

- ✓ Healthy, respectful and empowering relationships
- ✓ Collective strengths, skills, resources and capacity
- ✓ Correct behaviour and integrity of families and whānau
- ✓ Health functioning families and whānau
- ✓ Strong families and whānau

In combining the principles of Whānau Ora with a very specific focus on relationships, power dynamics and communication, there is the potential for Like Minds, Like Mine work to effect positive, pervasive and long-term change in attitudes and behaviour, reduce discrimination towards young people, and to more effectively emphasise the role discrimination has in contributing to mental health issues. There is significant scope for the Like Minds, Like Mine programme to use this combined approach to work with other organisations, agencies and providers (e.g. Whānau Ora programmes to reduce violence within families and to address 'bullying' in schools), in order to raise awareness of the nature of discriminatory abuse that young people experience and the immense impacts

discrimination has on young people's mental health.

While specific strategies can be readily adopted, the greater challenge is to consider discrimination within the broader social, cultural and historical context of young people's lives, to shift dominant cultural norms, and bring about systemic and institutional change to effectively reduce discriminatory abuse towards young people.

Study strengths and limitations

This study has provided some important insights into the experiences of young people affected by discrimination that is related to their mental health, adding to a somewhat scant body of literature. Importantly, it has contributed a New Zealand-specific perspective to the existing knowledge base, particularly given the inclusion of young people from a range of ethnic backgrounds.

However, the research is not without its limitations. Overall, recruitment of young people for the focus groups proved challenging, and resulted in fewer participants than initially anticipated (n=30 instead of n=70 to 80 participants). Despite the research team, cultural advisors and the advisory group making every effort[35] to ensure culturally appropriate research practice was used, in order to recruit young people from diverse backgrounds, there were particular barriers for Pasifika and young people from a refugee background.[36] The 'rainbow' focus group also had a low turnout.[37] It is recognised that basing a group on sexual and gender orientation may not necessarily be the most effective way of engaging young people whose experiences are likely to be diverse. In addition, a group forum may not be the most appropriate method to ensure participation by young rainbow people, especially those who are not 'out' about their sexuality or gender identity, and who do not want to talk about potentially sensitive issues with others.

Overall, it was also likely that many young people did not wish to talk about mental health issues in a group forum or with a group of strangers. Equally, some young people are likely not to want to attend a group forum to talk about personal issues, where there is a chance they will know other participants. The methods used in research with young people require careful consideration in future research of this kind, as a pre-determined methodology is not always the most effective. Alternative methods, which are more appropriate to the topic of inquiry and well suited to young people, are needed to ensure full participation by these population groups in future research about discrimination.

Conclusion

The findings of this research raise important issues about how young people conceptualise discrimination and mental health problems, and what they regard as important when asked about these issues. Participants clearly located their experiences of discriminatory abuse within a broad social and cultural context, and emphasised the role of healthy relationships at home and school as integral to reducing discrimination. The challenge for future Like Minds, Like Mine work is to develop a more holistic and appropriate approach to understanding young people's experiences of discrimination, which includes, but is not restricted to, mental health issues, and which recognises the role of all types of discrimination in contributing to, as well as exacerbating, mental health issues. This may necessitate reconsideration of the programme's approach to attitude and behaviour change, and the need to avoid stereotyping and reinforcing prejudice. The findings of this research also emphasise the importance of ensuring that strategies to reduce discrimination associated with mental illness are relevant to young people's realities and address the broad, systemic context.

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[35] The challenge of finding a recruitment method that would appeal to all young people was recognised, and the need for multiple approaches acknowledged. Other methods of recruiting were discussed, such as having a stronger focus on online promotion, and drivers to more effectively promote the research in young people's settings. The language used in advertising the research was also a key focus of discussion.

[36] While one Pasifika and two refugee specific groups (one for males and one for females) were organised, and various attempts were made to recruit young people from these backgrounds, no young people attended the groups.

[37] In addition, only lesbians attended.

Whaia e koe te iti kahurangi ki te tuohu koe me he maunga teitei me te aro ki te tuohu koe.

Reach for the stars that clothe the heavens, if you must bow let it be to a lofty mountain.

Never give up – you can reach your true potential.

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Appendix A

Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Young People, Mental Illness and Discrimination Research Information Form

Please read the following information before you agree to take part in a focus group.

1. What would participation in a focus group involve?
This would involve talking in a group of 6-8 people aged 18-24 who have similar experiences. The focus of the discussion will be on discrimination from the perspective of young people. The focus group will be facilitated by [insert facilitator and co-facilitator names]. The lead researcher is Heather Barnett. The research is being undertaken by the Mental Health Foundation.

2. What do I need to do?
If you decide to participate in a focus group please let [insert facilitator's name] know before [insert date]. Please contact [insert facilitator's email and cell phone]

Once you've confirmed your attendance just turn up on the day. No preparation is needed.

3. Where will the focus group take place and how long will it be?
The focus group is being held on [insert day, date, time, venue, location]. [Insert directions to venue]. The focus group will take up to two hours. The day after the focus group the facilitator will make contact with you (if you give consent) so you can talk about how you thought the group went and to give you an opportunity to make any further comments.

4. Will anyone know that I participated in a focus group or know what I said? Will I be identified in the research report?
The facilitator and other participants will know that you attended the focus group. However, all people attending the focus group will be asked to sign a consent form indicating that they won't identify anyone else who participated in the group. They will also be asked to agree to keep what people say in the group confidential.

The research team is not permitted to tell anyone that you participated in a focus group or to identify you in any way. No one who participates in a focus group will be identified individually in the research report. Although some people might want to be named in the research report, this could mean identifying other people, such as family or whānau. This means the researchers will not be identifying any individuals in the reporting of this research.

5. Digital Recording
The focus group discussion will be recorded. The recording will only be listened to by the research team and someone who will type up the recording into a word document (transcript). These people are not allowed to identify you or discuss what you say with people who are not on the research team. No one else will have access to this information. The transcript from the recording will be security saved and the hard copy stored in a locked filing cabinet. The digital recordings will be deleted at the completion of the research.

6. What if I decide I don't want to be involved in the focus group?
Your involvement in the focus group is voluntary and entirely up to you. You do not have to answer questions that you do not want to talk about at the focus group and you can leave the focus group at any time. If you decide to withdraw just let the facilitator know that you no longer want to participate in the research. You do not have to explain why you are withdrawing from the project.

7. How will I find out about the findings of the research?

At the focus group you will be given a Consent Form. On the Consent form you will be asked if you would like to receive a copy of the research report. We would also like to invite you to a presentation and/or launch of the research. We will need a contact address to send you a research report and/or invite. If you would like either of these opportunities please fill in your postal address on the Consent Form at the focus group.

8. What recognition will I receive for my time and involvement?

We will give you a $30 voucher in appreciation of your involvement in a focus group. This is a small gesture to thank you for participating in the research. Food and drinks will also be provided.

9. Who should I contact if I have any further questions?

If you have any questions about the focus group or any further queries about the research please contact Heather Barnett, senior researcher, Mental Health Foundation. Contact details:

heather@mentalhealth.org.nz
Ph: 04 801 03 53
Mental Health Foundation
Level 7 Education House
178 Willis Street
Wellington

Appendix B

Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Young People, Mental Illness and Discrimination Research Consent to Participate in Research

I have read the research Information Form which provides an outline of the project, ethical information and the facilitators' and researcher's contact details. I have been given an explanation of the research. I have had an opportunity to ask questions and have them answered to my satisfaction and know what is required of me. I know that the Mental Health Foundation is undertaking the research and who to contact if I have any queries.

I understand that taking part in this research is completely voluntary and that I may withdraw from the research at any time without reason. I understand that no information that could identify me will be used in any reports or in any forums where the research may be presented. I understand that the people who attend the Focus Group will be asked to keep what others in the group say confidential and not to identify anyone who attends the group.

Please put a **tick** in the box that you **DO** agree with
Please put an **X** in the box you **DO NOT** agree with

- ☐ I am over 18 years of age
- ☐ I have not been admitted to an inpatient unit in the past 3 months
- ☐ I agree to participate in a focus group
- ☐ I agree to have quotes used in the research findings as long as I am NOT identified in any way
- ☐ I agree to the focus group being digitally recorded and typed into a word document (for use only by the research team)
- ☐ I agree to keep what others in the group say, confidential, and will not name or identify any other person in the focus group
- ☐ I would like the facilitator to give me a call a day or two after the focus group to check out how I thought the focus group went
- ☐ I would like to receive a research report
- ☐ I would like to be invited to attend the launch and/or presentation of the research

PLEASE TURN OVER THE PAGE

Please Print Clearly

Name of participant: .....

Your Signature:.....

Phone number:.....

Email address for an invite to a presentation of the research

Address for report and/or launch .....

Date:

Name of facilitator(s): .....

Facilitator Signature:.....

Date:

Focus Group: .....

Location:.....

Kia Ora Thank You

Appendix C

Human Rights Commission Definition of Discrimination:

Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances.

Appendix D

Focus Group Questions

Section A: Meaning & Experiences of Discrimination

1. What does discrimination mean to you? (**Prompts:** What words come to mind? Refer to Human Rights Commission definition if needed)
2. Have you ever experienced discrimination in relation to mental health problems? What are your experiences of discrimination in relation to mental health problems? **Explain:** Can you tell us about your experiences?
3. What impact has discrimination had on you? (**Prompts:** How did/do you feel; what did/do you think; how did/do you react)
4. Are there other kinds of discrimination that affect your experience of mental health problems? **Explain:** Can you tell us about these?
5. What impact has discrimination had on your wellbeing?

Section B: Sources of Discrimination

6. In your experience, who or what were the main sources of discrimination against you because of *mental health problems?*
7. Who or what were the main sources of discrimination you've seen against other young people because of *mental health problems?*
8. In your experience, who or what were the main sources of discrimination against you because of *other kinds of discrimination?*
9. What do you think influences whether people discriminate or not? (**Prompt:** What are the things that influence discrimination occurring? What makes it more likely? Less likely?)
10. Where do you think discriminatory attitudes and behaviour come from?
11. Have you ever discriminated against someone? Why do you think you behaved in this way? What would have helped you not to discriminate? (**Prompts:** What are some ways we can get more people/places to do this? What do they need to do?)

Section C: Ways to Reduce Discrimination

12. What do you think would help to reduce discrimination relating to young people who experience mental health problems?
13. Are there practices, policies or procedures you would like to see changed to reduce discrimination against young people who experience mental health problems?
14. What can *friends of your age* do to reduce discrimination towards young people who experience mental health problems?
15. What can *family and whānau* do to reduce discrimination against young people who experience mental health problems?
16. What can *groups or organisations* do to reduce discrimination against young people who experience mental health problems?
17. Have you seen any strategies that helped to reduce discrimination against young people who experience mental health problems?
18. Do you recall particular individuals, staff or organisations that were not discriminatory towards young people who experience mental health problems? (**Prompt:** How did they show they were not discriminatory?)
19. What are some ways we could influence more people (or places) to behave in this way? (**Prompt:** What do they need to do?)

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