Evaluating social marketing messages in New Zealand's Like Minds Campaign and its effect on stigma

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Abstract

Background:

A key objective of government and social marketers is to remove the institutionalized stigma of mental illness, increasing mental health service uptake. While research has evaluated past campaigns based on changes in attitudes and beliefs, very little research has examined the communication messages used in social marketing campaigns.

Focus of the Article:

This impact evaluation research identifies the institutionalized cultural-moral norms incorporated into New Zealand's *Like Minds* mental health advertisements and examines how attitudes and beliefs changed over time in response to these norms.

Importance to the Social Marketing Field:

This research offers a new approach to social marketing evaluation and demonstrates the importance of consistent incorporation of cultural-moral institutional norms in social marketing campaigns.

Method:

Using macro-social marketing theory, thematic analysis is used to identify the cultural-moral institutional norms in the *Like Minds* campaign advertisements over a 10-year period (2002–2012).

Results:

The Like Minds campaign was found to have multiple cultural-moral institutional norms, such as Mental illness as a villain, Personal responsibility, and Inherent human dignity, as well as utilizing two different institutionalization processes of Socialization and Identity Formation. However, these norms were inconsistently and sometimes contradictorily presented and as a result, not all changes in mental health stigma beliefs and attitudes show long term change. Rates for service uptake also had mixed results during the campaign duration, though overall an increase in uptake was found.

Recommendations for Research and Practice:

The research highlights the importance of understanding the underlying institutionalized cultural-moral norms presented in communications and aligning those with the overall objectives of a social marketing campaign.

Limitations:

Like Minds campaign phases 2 to 5 are analyzed, phase 1 was inaccessible for analysis and advertisements after 2012 are not analyzed.

Keywords mental health, monitoring and evaluation, best practices, macro-social marketing, institutionalization

Mental health affects 1 in 6 people worldwide (Roser & Ritchie, 2017) and is the leading cause of the global disease burden (WHO, 2018). Social marketing campaigns for mental health are an important component of health promotion (Kruger et al., 2011; Levit et al., 2016; Phillipson et al., 2009). The implementation of strategies for promotion of services and prevention in mental health are key objectives for many countries, especially those targeted toward vulnerable populations (i.e., minorities, indigenous people), and directed in schools, workplaces, and via mass media campaigns (WHO, 2018).

However, nearly two-thirds of individuals never seek help, mainly due to stigma and discrimination (Henderson et al., 2013). Such institutionalized stigma refers to shared normative, regulative, and cultural-cognitive societal elements that shape acceptable behaviors, responses, activities, resource allocations, constraints, and rules for social functioning (Scott, 2014) regarding mental health. Therefore, a key objective of government and health promoters is removing the institutionalized stigma of mental illness to increase mental health service uptake. Such interventions include measures to counter mental health stigma and discrimination, foster (mentally) healthy workplaces and spaces, promote self-care, and build resilience in individuals and communities (Paterson et al., 2018).

Looking at these types of institutional norms and campaign effectiveness in shifting them (e.g., institutionalization or deinstitutionalization) is important as it contributes to understanding why many campaigns lack a long-term effect, change some aspects but not others, and often lack change in behavioral intentions (Evans-Lacko et al., 2013, 2014). Such institutional norms (made up of both social norms and values) create behavioral expectations for those with mental illnesses. Behavioral expectations show themselves as both external pressures on individuals from those that do not suffer from a mental illness as well as internal pressures within the sufferer themselves to act, think and behave in certain ways (Scott, 2014). Thus, an institutional norm of personal responsibility of the sufferer to regain their mental health, for instance, is extremely damaging (Corrigan et al., 2002) and counter to government objectives regarding mental health service uptake and mental illness recovery (Ministry of Health & Health Promotion Agency, 2014).

However, while a key focus of interventions is on removing institutionalized stigma of mental illness (i.e. how attitudes and behaviors become (de)normalized into social norms and beliefs—Kennedy, 2016), there is little research relating deinstitutionalization through social marketing. Current research on ***de***institutionalization in general explains theoretical change at a macro level according to societal pressures (Oliver, 1991) and as such, disempowers social marketers to make a difference through campaigns. The only literature linking ***in***stitutionalization and social marketing provides a theoretical road map for social marketers to follow when imbuing their campaigns with symbolic norms/institutional norms (Kennedy, 2016). That literature on macro-social marketing (Kennedy, 2016) states that cultural-moral norms can be used by social marketers to influence societal change and long term, change institutionalized norms. However, it has never been applied to a real-world setting. Consequently, the main aim of this paper is to apply macro-social marketing theory—which explains this process (Kennedy, 2016)—as a new approach to evaluate the effectiveness of the use of symbolic norms underlying a social marketing campaign. Our analysis focuses on mental illness stigma, specifically on New Zealand's *Like Minds, Like Mine* (*Like Minds*) program.

While many mental health campaigns and programs are implemented worldwide, New Zealand's *Like Minds, Like Mine* (*Like Minds*) program established in 1997 was one of the

first comprehensive national campaigns in the world to address mental illness stigma and discrimination (Ministry of Health & Health Promotion Agency, 2014). Yet, while *Like Minds* outcomes have been evaluated, as have similar campaigns such as Australia's *beyondblue* and the U.K's *Time to Change* (although the latter two to a much greater extent), the social marketing communication/messages and their underlying institutional norms have not been analyzed. Analyzing social marketing advertising is key to understanding the underlying use of institutional norms that drive social norm change and can provide a greater understanding of campaign performance.

The aim of this research is fulfilled through two objectives: 1) To identify the institutionalized cultural-moral norms incorporated into the *Like Minds* health promotion communication messages over 10 years; and, 2) To evaluate the *Like Minds* campaign effectiveness in changing institutionalized norms surrounding mental health stigma. To deliver this, we undertake a thematic analysis of the advertising from the *Like Minds* campaign using macro-social marketing theory (Kennedy, 2016) to uncover their representations of the underlying institutional norms around mental illness. The main contributions of this paper are a new approach to evaluate the cultural-moral institutional norms in social marketing campaigns, and a theoretically based explanation for campaign non/performance. Consequently, the main aim of this paper is to apply macro-social marketing theory to evaluate the effectiveness of the use of symbolic norms underlying a social marketing campaign.

What follows is first a review of mental health campaign evaluations, and explanation of macro-social marketing theory (Kennedy, 2016). This is followed by the thematic analysis of the campaigns spanning 10 years, and a campaign evaluation section to evaluate the campaigns' effectiveness by comparing secondary survey data with the findings of the thematic analysis. Lastly, we discuss the implications and limitations of the research and future research suggestions.

Background

Mental Health Campaign Evaluations

Many mental health mass media campaigns have been launched around the world. Commonly, social marketing campaigns directed at mental health aim to decrease the stigma against mental illness and increase awareness about and uptake of mental health care services available. The most evaluated (and comprehensive) are Australia's *beyondblue* and the U.K's *Time to Change*.

Since 2000, Australia has implemented a depression initiative, called *beyondblue*, to increase awareness, understanding, and attitudes of depression (Jorm et al., 2006). Studies compared high- and low-activity *beyondblue* states (the initiative varied between states due to funding differences) and found that high-activity states had greater improvement in the ability to recognize depression and more openness about depression (Jorm et al., 2006), and had more positive beliefs about the potential helpfulness of treatments (particularly counseling and medication; Jorm et al., 2005). Campaign awareness was also associated with better mental health literacy in young adults (Morgan & Jorm, 2007), but was found not to be specific to depression and anxiety disorders which was the campaigns main focus (Yap et al., 2012).

Similarly, the U.K introduced the *Time to Change* anti-mental health stigma program in 2007, and studies have found a significant and moderate effect of the campaign (Evans-Lacko et al., 2014). Research has shown that the social marketing campaign, particularly the use of social media, was associated with higher mental health knowledge, demonstrating greater tolerance and support, and increased reported and intended behaviors toward living with, working with, living nearby, and continuing a relationship with someone with a mental health illness (Sampogna et al., 2017). Additionally, awareness of the *Time to Change* campaign was associated with improved knowledge, attitudes and intended behavior (stigma related; Evans-Lacko et al., 2013), less discrimination from friends, family, neighbors, and employers (Henderson et al., 2013), and greater comfort in sharing mental health problems and intention to seek help (Henderson et al., 2017). Similarly, *Time to Change* social contact events were associated with improved attitudes and willingness to challenge stigma and discrimination (Evans-Lacko et al., 2013) and improved behavioral intentions (stigma) and campaign engagement (Evans-Lacko et al., 2012).

However, research also found no significant change in overall knowledge or intended behavior over the duration of the *Time to Change* campaign (Evans-Lacko et al., 2013), discrimination by mental health or physical health care professionals (Henderson et al., 2013), and possible confusion over its message (Abraham et al., 2010). Evans-Lacko et al. (2014) found that while attitudes related to prejudice and exclusion were more positive this was not the case for tolerance and support for community care; the campaign addressed prejudice and exclusion rather than communicating positive attitudes and support for mental illness sufferers (Evans-Lacko et al., 2014). These findings suggest the importance of messaging and framing in health promotion.

New Zealand's *Like Minds* Campaign has also been evaluated for its impact on attitudes. Twelve surveys were conducted to map the public knowledge of and attitudes to mental health and mental illness in response to the *Like Minds* Campaign (Wyllie & Lauder, 2012). Research shows improvements in national attitudes, especially among Māori, Pacific and young people (Wyllie & Lauder, 2012). In terms of discrimination, a study in 2014 showed that 89% of people reported at least "a little" unfair treatment in the last 12 months (Thornicroft et al., 2014), while an early study in 2006 demonstrated that discrimination occurred with friends and family (59%), while looking for employment (34%) and with mental health services (34%; Peterson et al., 2007). Results also demonstrate that more people are accessing specialist mental health and addiction services, which has increased by 78% since 2005/2006 with the greatest increases seen in Māori (169%), Pacific (156%), and young people (113%; Ministry of Health, 2019). However, significant fluctuations have been found between campaign phases, with attitudes and beliefs changing over time, and not always in a positive direction (Wyllie & Lauder, 2012).

To understand this variance, research has yet to examine the underlying institutionalized cultural-moral norms presented in the communications for mental health campaigns to explain why long-term change has not occurred in all target areas. This can be achieved by evaluating campaign's underlying institutional norms as per theories in macro-social marketing (a systems-level approach to behavior change; Kennedy, 2016).

Theory of Change: Macro-Social Marketing and Institutional Theory

Macro-social marketing is based on institutional theory which defines institutions as:

…symbolic and behavioral systems containing representational, constitutive, and normative rules together with regulatory mechanisms that define a common meaning system and give rise to distinctive actors and action routines. (Scott, 2014, p. 68)

Thus, institutions are made up of meanings, norms and rules, as well as material resources and behaviors that those symbolic elements produce, reproduce and sustain. Together and through interaction, these elements create stable, intergenerational meaning systems and social structures that are the social framework that are institutions (Scott, 2014). Macro-social marketing uses institutional theory to explain how a person or entity is influenced by their environment. As such, environmental expectations eventually form norms that are infused into people through socialization, identify formation, and sanctions (Scott, 2014). Institutionalized norms are taken-for-granted activities, which may include assumptions, actions, and beliefs that are maintained over time without need for justification or elaboration (Scott, 2014; Zucker, 1987). They differ slightly from our usual understanding of social norms as institutionalized norms are a normative system that includes both social norms and values. This introduces not only acceptable ways for achieving individual or group outcomes, but also valued outcomes worthy to be achieved (Blake & Davis, 1964). In our case, we focus on cultural-cognitive aspects of institutions, which go one step further to come to an agreement on a shared social reality and lens for meaning interpretation within a societal group (Scott, 2014). This is important in our context as these all add to create societal expectations of how those with a mental illness should think, act, and recover. The institutionalized stigma around mental illness and personal responsibility for recovery leading to lower levels of uptake of mental health services and poorer mental health outcomes (Rüsch et al., 2005).

The process of institutionalization is influenced by history and habits (Zucker, 1987). Much work has examined the process of institutionalization and the creation of new institutional norms, especially through the concepts of institutional work and entrepreneurship (Lawrence & Suddaby, 2006; Scott, 2014). To a small extent, examining the (de)institutionalization of stigmas has also entered the mental health field (Clair et al., 2016; Shen & Snowden, 2014). Clair et al. (2016) examines the social conditions associated with the reduction of public and structural stigma (i.e., credibility of new constructions, interaction of new constructions with existing ideologies, perceived linked fate between groups), while Shen and Snowden (2014) utilizes institutional theory to theorize the adoption and legitimacy of mental health policy. Thus, neither examines how deinstitutionalization is communicated in campaigns and its effect on performance.

When inadequacies of the status quo are highlighted as a crisis (i.e., a record number of suicides, long waiting list for mental health services) this may result in an erosion of institutionalized activities (i.e., practices, beliefs, attitudes) and create a drive to deinstitutionalize norms (Oliver, 1991). Kennedy (2016) proposes that the culmination of multiple social marketing interventions, over the long term, can see a change in institutionalized norms that perpetuate wicked problems (i.e., mental health stigma). Kennedy (2016) posits that cultural-moral institutional norms (such as mental illness stigma) are reinforced or de-emphasized based on communication's portrayal of symbolic institutional actions. Cultural-moral institutional norms are norms that define appropriate behaviors, meaning systems, roles, and expectations in society (Scott, 2014), and symbolic institutional actions are any aspect of a social marketing communication that portray these norms symbolically or objectively.

For instance, the model would suggest that cultural-moral institutional norms that support the inherent dignity of all humans (no matter their mental health status) could be incorporated into social marketing interventions both objectively (i.e., community events where people take turns to chat with a person with a mental illness on a couch) and symbolically (i.e., advertising showing people treating those diagnosed and undiagnosed with mental health issues equally) to address the stigma of mental illness (See Figure 1). For norms to be institutionalized, the macro-social marketing framework (Kennedy, 2016) proposes that social marketing, as well as social mechanisms such as family, friends, and workplaces, will incorporate new institutional norms in five different ways. These may be through socialization, a person's identity, sanctions against behaviors that go against the norm, and a person's use of the norms through re-interpreting them for their own use, or infusing them within their organization (See Figure 2 for the process of institutional change) (Kennedy, 2016).

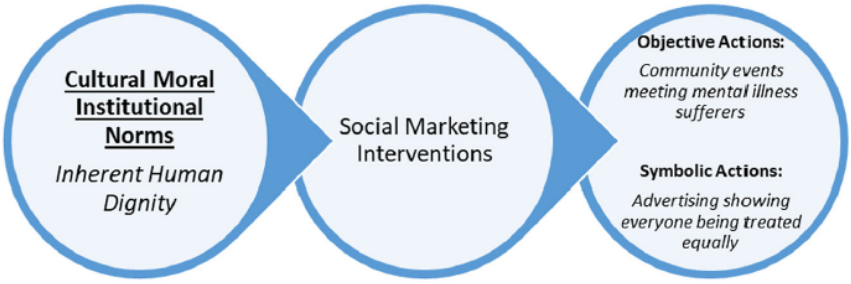

Figure 1. Social marketing communication of norms.

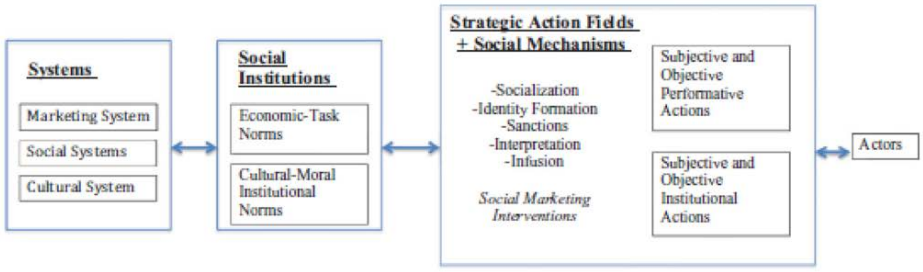

Figure 2. The process of institutional change (Kennedy, 2016).

The theory of macro-social marketing is an appropriate lens to evaluate social marketing campaigns' underlying cultural-moral institutional norms. The aim of the following analysis is to uncover the cultural-moral institutional norms incorporated into each *Like Minds* campaign, and discuss the change in use of norms over time, as well as examining the

potential effect that these communications and norms had on beliefs and attitudes regarding stigma around mental illness. What follows is a thematic analysis (Braun & Clarke, 2006) of the cultural-moral institutional norms in the *Like Minds* campaign advertisements over 10 years.

Method

All publicly available television advertisements from Phase 2 to 5 (Phase 1 is not publicly available and so was not analyzed) were analyzed. This amounted in a total of 21 advertisements which were accessed via the *Like Minds* YouTube channel and analyzed (accessed https://www.youtube.com/channel/UCcTcT-4tQP4I1csWQfdfLig).

These health promotion communications were thematically analyzed (Braun & Clarke, 2006) using the macro-social marketing framework (Kennedy, 2016) to identify cultural-moral institutional norms and their objective and symbolic actions as per previous literature (Arnold et al., 2001; Jakobson, 1960). Specifically, the messages of the advertisements were analyzed to uncover these norms (Arnold et al., 2001; Jakobson, 1960). Norms were identified through the connotative meanings of the advertisements which were derived from the advertisement script, as well as the images including the actors, facial expressions, interactions, and scene settings which are particularly necessary to uncover symbolic meaning hidden beyond the script. Two coders undertook the thematic analysis separately and then came together to discuss and agree on common themes to ensure inter-coder reliability (MacPhail et al., 2016). These themes are presented in the findings in chronological order (as opposed to being presented by theme) so that evaluation over time may be undertaken. The themes regard the different norms shown in the advertisements (Mental illness as a villain, Personal responsibility, and Inherent human dignity), as well as the different institutionalization processes (Socialization and Identity formation).

Findings

The aim of the *Like Minds* program is "a socially inclusive New Zealand that is free of stigma and discrimination toward people with mental illness" (Ministry of Health & Health Promotion Agency, 2014, p. 6). The program is based on the social model of disability (discrimination is created by society, not by individuals with disabilities) and human rights (inherent dignity and value of individuals) and is a multi-level approach with leadership and coordination with people with mental illness, public contact with people with mental illness, and program activities which highlight socially inclusive behaviors (Ministry of Health & Health Promotion Agency, 2014).

Overall, our findings suggest the phases present symbolic themes that come under cultural-moral institutional norms. We identified these themes as mental illness as a villain, personal responsibility and inherent human dignity. We found the communications sought to incorporate the norms into the institutional environment by using two forms of institutionalization—socialization and identity formation.

Phase 2

Phase 2 (2002) used the tagline "You make the difference" and featured famous New Zealanders with experience of mental illness engaging with other celebrities. The aim of the second phase was to (a) build awareness and positive attitudes of mental illness, (b) address

the effects of mental illness on individuals, (c) show mental illness as personally relevant and (d) model “good” behavior (Wyllie & Lauder, 2012).

The direct messages of this phase of the campaign show people living with mental illness like everyone else and thus implying that they are “normal” along with statements that mental illness is not a big deal and is itself “pretty normal.” Those with mental illness are portrayed in their everyday settings showing that their life is the same as others. The scenes focus on people in family, work, and friendship settings—de-coupling the stigma that those with mental illness somehow do not adopt these in everyday life. For instance, symbolically, this rejects the institutional action of the “illness” aspect within the cultural-moral norm of stigmatization surrounding mental illness. Beforehand, those with mental illness are seen as “ill” and so not fit for normal participation in everyday society by showing that they do participate in everyday society. Thus, the mental illness stigma as a cultural-moral institutional norm is replaced with other norms surrounding family, career, love, and togetherness. The performative action that is presented here is of talking about the symptoms and effects of mental illness as appropriate and positive and is aimed at the friends and family of individuals with mental illness.

In analyzing the symbolic meaning of this phase of promotions, the four television advertisements paint the picture of mental illness as an entity in itself that is portrayed as a villain. The storyline of the warrior/hero versus the villain is introduced where the person with a mental illness needs to find the strength to “fight” the “demon” which drags individuals with mental illness into a “black cloud” and “darkness.” However, critically, the articulation of the old cultural moral institutional norm of stigma is reinforced through these symbolic institutional actions. Utilizing such negative framing gives the underlying impression that mental illness is not “normal” and not “ok” because their personal identity is taken over by the villainous demon of mental illness. Specifically, the messages highlight the negative connotations of mental illness.

The cultural-moral institutional norm is presented by comments made by individuals with mental illness and their friend, for example, a friend is proud they can face up to the “demon,” which takes “guts,” and individuals with mental illness replace the word depression with “freaking out” as “people say snap out of it” otherwise. On top of this, individuals with mental illness are also mantled with the performative action that they take personal responsibility for their recovery in this set of promotions. For instance, they are set as the hero or warrior that must “conquer” and “beat” the villain of mental illness. The sufferer is said to be more aware of themselves, and their fallibilities and so is portrayed as the somewhat unskilled or unprepared warrior (as they need to “handle it” themselves) against the evil mental illness that takes them over. This can be seen as inadvertently using socialization to draw up expectations of how individuals with mental illness should act and treat their mental illness.

Phase 3

Phase 3 (2003–2004) included non-celebrities and the tagline “Know me before you judge me” and built on the first two campaigns (awareness, positive attitudes, understanding, and acceptance) and focused on similar positive attitudes toward serious mental illnesses such as depression, bi-polar and schizophrenia. Phase 3 was the first to be more ethnically diverse and specific in their campaign. The aims of the campaign included (a) decreasing public fear

around mental illness, and (b) emphasizing recovery, inclusion, and contribution of people with mental illness to other people's lives (Wyllie & Lauder, 2012).

Again, four television advertisements were released featuring two women and two men, from different ethnic backgrounds and ages, in multiple scenes with their family and friends. In these, individuals with mental illness are portrayed in their different societal roles, such as Mother, Sister, and Auntie. The cultural-moral institutional norm that is symbolically represented here is the inherent human dignity that every person holds, no matter their mental state. This norm is the potential replacement norm for that of mental illness stigma. The norm is shown through symbolic institutional actions that touch on identity, downplaying the first phase's emphasis on the mental illness as an entity in itself. The emphasis in Stage Three is to show individuals with mental illness as an everyday person, showing the characteristics of their personality that supersede their mental illness. Thus, individuals with mental illness are shown as "always being there for me," being the one that can "make me laugh," "a great mentor," as having "an inner radiance," a person who "gives me lots of cuddles," and a friend who you can "bank on…being there." Their societal roles are seen as important in creating their self-identity as Brother, Sister, Uncle, Mother, and even employee. These underlying symbolic norms of the person having an inherent human dignity regardless of their mental illness provides a clear base for moving the aims of the campaign forward and undermining the stigma of mental illness. In using identity formation as a tool for institutionalization, the cultural-moral institutional norms presented here do not allow mental illness an identity of its own, as have previous phases (with mental illness being seen as a villain) and instead empower individuals with mental illness to embrace their own identities (e.g., Aunt, Uncle, comedian, mentor, friend).

Phase 4

The next phase, Phase 4 (2007), centered on Aubrey Quinn and his wife and family. The aims of this campaign were to demonstrate (a) the strength of individuals with mental illness, (b) the contribution of people with mental illness to other people's lives, including family, friends and employers, (c) appropriate, supportive and non-discriminatory behaviors, and lastly, (d) emphasize the self-responsibility, recovery, and sense of hope for recovery, for those with mental illness (Wyllie & Lauder, 2012).

Phase 4 introduces objective institutional actions that friends, family, and employers can undertake for those with mental illness. Particularly, friends and family are portrayed to treat individuals with mental illness the same as anyone else. For instance the featured employer is said to have "treated him like everyone else," and friends talk about how they treated him the same, carried on "as normal," and "just [be their] friend," and to see if they "need a hand" with day to day "practical" things, and keeping a positive frame of mind. Thus, friends and family are socialized into behaviors that support wellness and are shown the positive outcomes of this as strengthening friendships and marriages, decreasing the power of the cultural moral institutional norm of stigmatization.

Symbolically in institutional actions, friends and family are symbolized as a "sidekick" for the hero. They empower the hero to rescue themselves and to "take on life" again. Specifically, the person is seen more as a hero or savior than a warrior here as they have given the "gift" of open communication to their friends and colleagues regarding their mental illness. This positive image shows a self-aware person able to enlighten those around them

about mental illness. This fights the stigma of an unprepared warrior from previous phases of communications.

Symbolic images in the background of the advertisements show the individual with mental illness again as a functioning member of society, further reinforcing a change in cultural moral norms around mental illness to that of inherent human dignity. The introduced theme of personal responsibility, however, we believe can be seen as problematic. Personal responsibility in itself can add to the negative stigma surrounding mental illness as it leads symbolically to individuals with mental illness being at fault (Corrigan et al., 2002) and thus, potentially blamed if they do not return to "normal" and "get back out there again" in society. While those with mental illness are overtly encouraged to accept the way they are, we believe in referring to the mental illness causing "failings" this symbolism negatively impacts the view of what again, the "evil" mental illness "does to" a person. We contend in treating the sufferer as "normal" instead of accepting them as they now have become, individuals with mental illness are expected to do their work and not be treated differently, for instance with regard to working, the sufferer is told "Yep, you can do it and [the employer] expects you to do it."

Adding to the symbolic messaging of the campaign, mental illness identity is further expanded upon here. Unfortunately, the negative connotations of mental illness for their identity is focused upon, we believe undoing some of the norm changes from Phase 3. For example, the comment "[People] don't take them [individual with mental illness] for who they are, they take them for what they are" is made by Aubrey's employer, implying that mental illness dehumanizes a person, giving power again to the "evil entity"—mental illness.

So, the symbolic push may have somewhat of an unintended outcome. While the overt messaging is to give objective institutional actions for friends, family, and employers to undertake to interact with and treat individuals with mental illness as "normal," this is juxtaposed with the symbolic messaging that the person themselves should strive to become "normal" and so should be treated as such and with the same societal expectations. However, this doesn't take into account the position of the mentally ill as a vulnerable population that requires some more help than others to meet their societal expectations (Corrigan et al., 2002; Henderson et al., 2013). This puts more pressure on those with mental illness to meet those expectations and can increase the stigma should the person not fulfill those expectations (Rüsch et al., 2005). The counter to this is hinted at within the advertising with the theme of persistence and commitment for friends and family to keep trying to interact with those who are diagnosed with mental illness, but we contend this performative action is not met with a corresponding institutional action.

Phase 5

Phase 5 (2010–2012) featured the taglines "Stay involved and be a part of this persons recovery" and "Stay there and stay strong—Here's how." The campaign focused on family and friends, particularly on (a) providing a support network, (b) awareness of discriminatory behavior, and (c) demonstrating the possibility of recovery (Wyllie & Lauder, 2012).

This final stage in our analysis shows a further drive toward the new cultural moral institutional norm of inherent human dignity. The advertisement does this by symbolic institutional actions that call into question exactly what "normal" is. Here, friends give those with mental illnesses "unconditional acceptance" ensuring them that "it is ok to go through

what you're going through." For instance, one conversation between friends has the individual with mental illness saying that her friend was good because she reminded her that when she was "well," she was "kind," "unique" and "precious." Her friend interrupts her to say that she is currently those things—regardless of her mental state. The norm shown here is inherent human dignity, as no matter the state of mind of the individual with mental illness, they deserve to be treated the same as everyone else. Also, the objective institutional actions of how to be a good and loyal friend are further developed. Specifically, loyalty, having faith, empowering those with mental illness, being humble, and being persistent is displayed in such phrases as "We're friends not just because we go through the good times, but because we go through the bad times as well" and "when you're ready, I'll be here." There is unconditional acceptance through good and bad times, and the role of a friend is not trying to "fix" the person or be a therapist, but instead to be present and supportive. This moves the norms away from a focus on the mental illness as an entity instead to the person as someone with inherent dignity no matter their mental state.

Finally, moving beyond the villain and warrior symbolic institutional actions which epitomize the personal responsibility aspect of mental illness, friends and family are seen as working with and supporting sufferers through their everyday life. For instance, one person states that "We needed to go out there as a family and find that service that could help us" and friends state they are not there to "correct" or "fix" the person. Instead a symbolic institutional action of a tribal support system is implied here, where the person is not left on their own.

Campaign Evaluation

This research has sought to identify the institutionalized norms incorporated into the *Like Minds* health promotion communication messages and evaluates the campaigns' effectiveness in changing institutionalized norms surrounding mental health stigma. This is an exploratory study of a new approach to evaluate long term campaign messaging. Its theoretical contribution is that it applies macro-social marketing theory to a longer-term program evaluation. To further extend our discussion we next discuss empirical indicators of deinstitutionalization of norms around mental illness stigma from campaign evaluation reports (based on the report by Wyllie & Lauder, 2012, seen in Table 1).

Public attitude surveys show some change around mental health stigma in New Zealand, in which attitudes toward people with mental illness have improved, especially among Māori, Pasifika, and young people (Phoenix Research, 2011). However, while these assessments demonstrate the success of the *Like Minds* campaign, we will next examine attitudes, beliefs and campaign message recall at each phase in conjunction with their purpose and communication of institutional cultural-moral norms to provide a more in-depth evaluation and discussion. As such, the assumption is that a reduction in actions, beliefs and attitudes related to the overall institutional norm of mental health stigma, will show a move toward its deinstitutionalization and thus eradication (Oliver, 1991). Such eradication may well show increases in mental health service uptake.

Table 1. Survey findings overview (adapted from Wyllie and Lauder, 2012)

Phase	No ads	1	3.1	3.2	3.3 (low ads)	4.1	4.2 (low ads)	5.1	5.2
Attitudes (%)									
People are more accepting of people with mental illness than they used to be						67	61[d]	64	67[a]
Once a person gets a mental illness they are always unwell	53	61[c]	65	54[d]	60[c]	64[c]	63	60	62
People who have had a mental illness are never going to be able to contribute much to society	77	84[c]	90	86[d]	84	84	89[c]	87	89
People who have a mental illness are more likely than other people to be dangerous	27	36	41	36[d]	38	41	36[d]	41[a]	39
Providing support to someone living with a mental illness would be difficult							15	22[c]	20[a]
People with mental illness need to just stop feeling sorry for themselves					60	58	62	68[c]	67[a]
Beliefs									
What individuals can do to be supportive of people with mental illness (%)									
Give support: offer support/ be there for them					32	38[c]	43[c]	47	49[a]
Talk/ listen to them: talk about their illness/ share the problem/ work through the issues					36	29[d]	40[c]	43	38
Treat them as normal people					23	35[c]	33	30	26
Help them with their illness: with medication/ treatment/ seeking help					18	11[d]	16[c]	19	21[a]
Be more understanding of their situation/ more open					31	17[d]	16	15	15
Become better educated on the illness: learn about different types of mental illness/ symptoms/ triggers/ treatments/ behaviours/ effects/ signs of regression					28	13[d]	12	12	13
Accept their illness/ accept them for who they are					19	12[d]	9[d]	12	9
Help them with personal matters: family situations/ money/ needs/ wants					9	6[d]	12[c]	10	9[b]
Visit them/ keep in contact/ phone					0	0	0	6[a]	9[a]
Don't exclude/reject them					6	10	12	6[d]	9[b]
Offer friendship					8	8	11[c]	11	8[b]
Don't be judgemental					18	9[d]	10	8	7[b]
Don't discriminate (unspecified)					5	7	5[d]	9[c]	5
Include them in activities – coffee/shopping/parties					0	0	9[c]	8	5[b]
Be more patient/ tolerant					6	4[d]	4	4	3
Don't change the way you act/ talk					0	0	0	0	3[a]
Have empathy/compassion					2	2	3	4	2[a]
Observe them/ be vigilant/ look for signs/ symptoms					3	5	4	3	2[b]
Messages recalled from campaign (%)									
Should be more accepting/ supportive/ don't discriminate			33	52	60[c]	67[c]	75[c]	71	74
Be supportive/ tell them they are not alone			0	6[c]	5	21[c]	32[c]	34	38[a]
Should be more accepting			17	28	28	29	25	27	23
Friends and family can help them through			0	0	0	0	0	9[c]	16[c]
Be there/ stay involved			0	0	0	0	0	7[c]	13[a]
Treat them as equals/ not different from anyone else/don't discriminate			2	12[c]	17[c]	29[c]	29	13[d]	9[b]
Should be given a chance			0	3	4	5	9[d]	7	8
Be less judgemental			7	12	20[c]	9[d]	10	6[d]	5[b]
It can happen to anyone			57	53	44[d]	34[d]	27[d]	36[c]	37[a]
Still normal people/ same as everyone else			0	19[c]	18	21	14[d]	21[c]	19[a]
It is more common than you think			7	14	13	7[d]	9	10	11
It can happen to anyone			40	27	19[d]	10[d]	6[d]	9	10[a]
Should not be ashamed			13	18	14[d]	21[c]	19	24[c]	22
Not such a bad thing			6	0[d]	4[c]	10[c]	8	11	11
Not something to be ashamed of			6	13	6[d]	5	3[d]	7[c]	5[a]
Not something to be afraid of			3	5	3	7[c]	7	5[d]	5[b]
It is an illness like any other illness			0	2	3	2	2	3	4[a]
There is help/ treatment			7	10[c]	8	11	16[c]	23[c]	20
There is help out there			4	3	4	7[c]	11[c]	17[c]	13[d]
Can overcome mental illness			0	4[c]	1[d]	3[c]	5[c]	4	5
Promoting awareness			8	12	9[d]	15[c]	10[d]	12	16[a]
Not a barrier/ can still lead a normal life			30	18[d]	23[c]	10[d]	8	6	4[b]

Note: Where campaign phases included more than one survey, we have displayed these in chronological order (i.e., 3.1, 3.2, 3.3)
Keys:
[a]Denotes a statistically significant improvement since 4.2 (low ads) (between phases 4 & 5) [b]Denotes a statistically significant worsening since 4.2 (low ads) (between phases 4 & 5) [c]Denotes a statistically significant improvement since previous survey
[d]Denotes a statistically significant worsening since previous survey

Table 1. Survey findings overview (adapted from Wyllie and Lauder, 2012)

Our analysis shows that social marketing interventions incorporated objective and symbolic performative and symbolic institutional actions to drive change, as can be seen in our findings. It was found that the original cultural-moral institutional norm the campaign was aiming to change was the stigma around mental illness. Throughout the different phases, the replacement norm was that of an inherent human dignity (regardless of mental state), which was successful in part. The use of objective institutional actions and symbolic institutional actions at times had a reinforcing effect on the original norm of mental illness stigma, as seen with significant drops in attitudes and beliefs around normality of mental illness in Phase 4. For example, message recalls decreased for judgement, specifically on normality, "it can happen to anyone" (44% to 34%), "it is more common than you think" (13% to 7%), and mental health effects, "not a barrier/can still lead a normal life" (23% to 10%).

Specifically, referring back to the institutional norms findings, one can see that the key norms around "be[ing] more understanding of their situation/more open" (from 31% to 17%), "don't be judgmental" (from 18% to 9%), and "be less judgmental" (20% to 9%), have large decreases which we posit can be attributed to the institutional norm presented on personal responsibility and the negative personal identity aspects which the communications focused on. For instance, objective institutional actions that drove personal responsibility for wellness into the hands of those with mental illness reinforced stigma as it could lead to blame for the person not being "normal." Equally, by emphasizing that mental illness was an evil villainous entity in symbolic institutional actions, this gave the illness power over the sufferer who then had to "fight" against the stigma and their illness. At these times there was a decrease in mental service uptake. However, at other times the messages reinforced the new norm of human dignity, which was seen in Phase 4 with significant increases in recovery, support, and equality. At this point there was a rise of mental service uptake by 18.5% (Ministry of Health, 2014).

The positive increase in Phase 4 attitudes and beliefs was seen in mental illness perceptions, and treating mental illness sufferers normally. The item "once a person gets a mental illness, they are always unwell (reversed)" increased from 54% to 60% in pre-Phase 4, and also increased to 64% in Phase 4. Similarly, beliefs in helping people with mental illness increased for "give support: offer support/be there for them" (32% in pre-Phase 4 to 38% in Phase 4), "treat them as normal people" (from 23% to 35%), and "Don't discriminate (unspecified)" (from 5% to 7%). Messages recalled from the campaign also showed a positive increase, especially those around support and equality. This included the items "should be more accepting/supportive/don't discriminate" (60% to 67%), "be supportive/tell them they are not alone" (5% to 21%), "treat them as equals/ not different from anyone else/don't discriminate" (17% to 29%), "not such a bad thing" (from 4% to 10%), and "there is help out there" (from 4% to 7%).

Institutional actions that supported the drive toward replacing the cultural-moral norm of stigma with inherent human dignity were the constant representation of individuals with mental illness as functioning members of society, who were able to partake of other cultural-moral norms such as career success, love, belongingness, and friendship. Adding to this, the objective institutional actions surrounding how to be a good family member, friend, or employer for someone with a mental illness, which brought into question what "normal" was, further drove cultural moral institutional norms toward human dignity. This was especially seen in Phase 4 and 5 which showed a significant increase in beliefs related to support. For example, in Phase 5, four beliefs showed positive increases, "give support: offer support/be there for them" (from 43% to 47%), "help them with their illness: with

medication/treatment/seeking help" (16% to 21%), "visit them/keep in contact/ phone" (0% to 9%), and "don't change the way you act/talk" (0% to 3%). Positively, introducing the theme of a tribe or group support system into the symbolic institutional actions, decreased the foothold that personal responsibility created in the original stigma norm. Yet, Phase 4 also saw a statistically significant decrease in beliefs and attitudes toward mental illness normality, perhaps in relation to the advertisement messaging indicating that those with mental illness themselves should strive to become "normal." It is unclear whether the increase in service uptake after phase 4 was due to the drive toward human dignity or striving to be "normal" and is an area for future research. However, given the discussion below, we propose that messages of support and human dignity drove uptake more than normality.

Socialization and identity formation took place within these campaigns, and these drove a change in the broader cultural-moral institutional norm of stigmatization of mental illness. In the campaign we did not see the use of sanctions, interpretation or infusion, which are commonly used in the institutionalization process.

Through focusing on objective institutional actions that friends, family, and employers can take and did take, socialization drove some institutionalization of the new norm of human dignity. Indeed, Phase 5 showed a significant improvement in support, which messaging targeted and communicated through socialization. Further to those statistics presented previously on Phase 5, message recalls also showed positive improvement for those related to support, "be supportive/tell them they are not alone" (32% to 38%), "friends and family can help them through" (0% to 16%), "be there/stay involved" (0% to 13%), and beliefs surrounding normality of mental illness, "still normal people/ same as everyone else" (14% to 19%), "it can happen to anyone" (27% to 37%), and "not something to be ashamed of" (3% to 5%).

Through looking at the personal identity of someone with a mental illness superseding their mental illness, this allows people to form their own identities, leaving out mental illness, and supporting the new norm of inherent human dignity. Phase 3 showed significant improvement for message recalls about being supportive, treating everyone equally and seeing mental illness as nothing to be ashamed of, the ability to overcome and the availability of treatment. Items such as the following showed message recall positively increasing, for instance "be supportive/tell them they are not alone" (from 0% to 6%), "treat them as equals/not different from anyone else/don't discriminate" (from 2% to 12%), "should not be ashamed" (from 13% to 18%), "there is help/treatment" (from 7% to 10%) and "can overcome mental illness" (from 0% to 4%). These changes reflect positively on the messages used within communications—friends and family are symbolized as a "sidekick," and people with mental illness are shown as functioning members of society.

Implications

The research has two main implications. Firstly, we utilize a theoretical basis to macro-level change to identify and discuss the institutionalized cultural-moral norms incorporated into social marketing campaigns. Secondly, we provide a macro-level evaluation of the Like Minds campaign.

Implications for social marketers from this research stem from providing a more practical approach to campaign creation and evaluation to gauge effectiveness. Previous literature in macro-social marketing has provided conceptual explication of the theory and processes

(Kennedy, 2016). However, this theory has not been applied to messaging in campaign evaluation. Utilizing macro social marketing theory, our approach provides insight into why campaigns may fail to bring about long term effects, or have mixed results. As such, symbolic meanings behind long term campaign messaging is also important to consider beyond objective messages and goals. For instance, conducting analysis of both objective and socio-cultural norms can ensure consistent reinforcement of key norms to support their institutionalization.

Our campaign evaluation provides support for incorporation of institutional norms into underlying symbolic messaging within promotion campaign creation. Semiotics supports this assumption that such symbolic meaning can influence individuals, and is important to refine for effective change to occur (Mick, 1986). Thus, the advantage of using this method to study symbolic meaning is that it approaches the analysis of meaning systematically, through looking at the structures of meaning producing events (Mick, 1986). The *Like Minds* campaign was found to have multiple and conflicting underlying institutional norms and as a consequence, its outcomes (i.e., effect on attitudes and beliefs) are also mixed. For example, rates[1] for service uptake fell between 2001/2002 and only increased again in 2005/2006 (after phase 3; Ministry of Health, 2013). A greater increase of uptake was also seen between 2007/2008 and 2008/2009, possibly measuring the positive impact of the Fourth phase (Ministry of Health, 2013). Overall, a rise has been seen by the uptake of mental health and addiction services, with a rise of 18.5%[1] (Ministry of Health, 2014). Our findings highlight the importance of understanding the underlying institutionalized cultural-moral norms presented in communications and aligning those with the overall objectives of the campaign.

The research also provides specifics on the most effective symbolic norms to apply to decrease stigma around mental illness in future social marketing campaigns. Incorporation of cultural-moral institutional norms supporting each person's inherent human dignity (no matter their mental health) seemed to provide the greatest positive change in stigma related attitudes, beliefs and behaviors. In this case, anything that shows those with a mental illness as functioning members of society. Additionally, showing others how to objectively provide support for those with a mental illness and how to treat them with dignity can include how to provide support whether it be to a family member, friend or employee, without implying the sufferer is not "normal." Such steps, as displayed in the campaign, helps to socialize the new institutional norm toward human dignity and away from stigmatization.

Limitations and Future Research

The limitations of this study must also be noted which offer opportunities for future research. The research did not have access to the raw data and so were reliant on information released to the public. Future research in coordination with the Health Promotion Agency of New Zealand would be of benefit. Future research is also needed to evaluate further iterations (2012–2019) of the Like Minds campaign, as funding and objectives during this time might have changed due to organizational restructuring and (political) responsibility changes.

Thematic analysis is also a qualitative method subject to its own limitations. However, considering the exploratory nature of the study the research method was appropriate (Stebbins, 2001). The use of two coders also aids in reliability (MacPhail et al., 2016). As the mediums of social marketing campaigns become increasing important, such as online and social media (Levit et al., 2016; Phillipson et al., 2009), so too should the content and framing of these messages (Cheng et al., 2011; Yang, 2018) and their subsequent impact on

attitudes, beliefs and behaviors. In addition, there is still a lack of research on deinstitutionalization of social beliefs and attitudes, so future research may benefit from social movement and sociological accounts of slavery, women, and gay rights to understand the process of (bottom-up) social change.

Conclusion

Our analysis demonstrates the importance of examining the longevity of attitudes, beliefs, and campaign message recalls in relation to the underlying institutional norms in messages in promotional material. The research provides two key contributions to the social marketing literature. The first is to provide an evaluation of the effectiveness of the Like Minds campaign. The second, to provide a new approach for analyzing social marketing effectiveness for macro-level change. Overall, the evaluation found that the *Like Minds* campaign resulted in a change in attitudes and beliefs, but not always consistently or positively due to changes in the communication of underlying institutional norms. For example, contradictory and potentially dangerous attitudinal changes were found in the earlier phases (i.e., assigning personal responsibility for mental illness). Positively, mental health service uptake has increased during the five campaign phases. Yet, overall, it seems short-, rather than long-term change may be the legacy of *Like Minds* in terms of beliefs and attitudes toward mental illness since promotional messages change as new objectives come into play and new institutional norms are communicated. Indeed, changing societal level structures may be infeasible with a campaign of short duration, especially considering the changing norms portrayed within the communications.

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Notes

1.Per 100,000 population, age-standardized to the World Health Organization (WHO) world standard population.

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