

# Appendix 1

## APPENDIX 1

### Population Groups

#### Adults

Adulthood is a time of major change, particularly in the areas of parenting and work. It can be extremely stressful. Establishing and maintaining committed relationships as well as childbearing and effective parenting are all part of the equation. At the same time, finding work, both paid and unpaid, is crucial. Meaningful work is important for mental health and income-producing work (employment) and has been shown to be a major determinant of mental, physical and social health for men and women (Raeburn 1999).

Stressful life events are also strongly linked to mental health problems and illness in adulthood. These external 'stressors' have been found to precede depression in around 50 percent of cases (Judd 1997). There have been successful prevention interventions in this area, (e.g. those designed for adults experiencing divorce and bereavement (Raphael 1977)).

The stresses experienced by adults as a result of low income, unemployment, poor housing, and social isolation, must be acknowledged and reflected in action to promote mental health and wellbeing.

#### Disadvantaged Groups

Demographic information shows that groups experiencing economic and social disadvantage have more mental health problems than other groups. Research shows that low socioeconomic status, and poverty in particular, makes it more difficult for people to maintain good mental health. This relates not only to the direct stress of poverty (resulting in poor housing, lack of meaningful work, for example) but also to the stress of being powerless to change this situation. There is compelling evidence that social class, irrespective of racial and ethnic background, is associated with higher rates of mental illness. Poverty, powerlessness, exploitation and discrimination are major causative factors (Albee and Ryan 1998).

It is common for families/whānau to experience many difficulties at the same time. Problems of unemployment, lack of social support and depression often occur at the same time, as do marital difficulties and depression. Family/whānau breakdown and social adversity are also closely linked. Socially disadvantaged families may be more difficult to reach through preventive programmes (Sanders et al 2000). Groups experiencing disadvantage also experience discrimination. The University of Surrey (1998) found the most common result of discrimination to be lower self-esteem, social isolation, depression and anxiety, drug and alcohol misuse and suicidal feelings.

#### People Affected by Mental Illness

One of the principles of the New Zealand Health Strategy is to promote the active involvement of consumers and communities at all levels of policy development. People who have experience of mental illness have a vital contribution to make to our understanding of illness prevention and as advocates for mental health promotion.

Mental health promotion interventions/activities are applied to the whole of the community, including people with experience of mental illness. As with all population groups, access to

social support, strong communities, adequate housing and meaningful employment will all promote better mental health for people who have experienced mental illness.

A central theme for service users is their experience of the stigma and discrimination associated with mental illness and the denial of their rights of citizenship (Sayce 2000). As Sayce comments, 'for many people, life is a series of interlocking, often mutually reinforcing, exclusions'.

The Mental Health Commission's *Blueprint* states that 'a discrimination-free environment is necessary if the Government's Mental Health Strategy is to be implemented' (MHC 1998:19). A public health programme to achieve this goal the Project to Counter Stigma and Discrimination Associated with Mental Illness has been under way since 1997. The project, under the brand name 'Like Minds, Like Mine', Whakaitia te Whakawhiu i te Tangata, provides an example of how service users/tangata whaiora can be involved in the planning, delivery and implementation of mental health promotion programmes. People with experience of mental illness provide advice and leadership through a national advisory group (NAG). In the South Island the project is guided and provided by district advisory groups (DAGs) made up of partnerships of people with experience of mental illness, mental health providers and public health promoters.

***The National Mental Health Standards (18) also require mental health services to promote mental health and community acceptance of people affected by mental illness and mental health problems.***

### Māori

Information on the use of mental health and related services indicates that Māori have more mental health problems than the general population. Although we know about mental health problems and their likely causes there is no way of measuring the more positive signs of good mental health. For this reason we cannot say what the overall mental health status of Māori is or, for that matter, the general population in New Zealand.

*Building on Strengths* outlines action that aims to reduce the disparities in mental health experienced by Māori and the approaches and models described in this document are proposed to ensure that actions are delivered in a manner that is relevant to Māori.

The New Zealand Health Strategy recognises the special relationship between Māori and the Crown under the Treaty of Waitangi. It also signals an intention to reduce inequalities in health outcomes, which is particularly evident for Māori. One of the strategy goals centres on Māori development in health, which includes building Māori capacity at all levels, enabling Māori communities to identify and provide for their own health needs, collecting high quality information, and supporting workforce development for Māori.

### Pacific Peoples

In New Zealand there are at least seven sizeable Pacific groups. Each Pacific community is unique, and therefore, the way in which their needs are perceived and resolved needs to be independent of the others.

In general there is a lack of research on the mental health of Pacific peoples within the New Zealand context (Bathgate and Pulotu-Endemann, cited in: Ellis and Collings 1997). Some protective factors that were identified by Bathgate and Pulotu-Endemann included:

- Support networks and cultural expressions, such as awareness and esteem for their own culture.
- Exercise of authority by elders and church leaders.
- Parenting, including successful adaptation to coexistence with host culture.
- Two-parent and extended family/whānau life.

Also included is economic security, including satisfactory employment and adequate housing.

Programmes that seek to improve the mental health of Pacific peoples must be delivered in a way that is relevant and responsive to the realities and experiences of those families. Improving Pacific health is expected to be achieved through two key mechanisms:

- Improving responsiveness and accountability of public sector agencies to Pacific health needs and priorities (Ministry of Pacific Island Affairs 1999).
- Building the capacity of Pacific people through provider, workforce and professional development and improved social service delivery (e.g. lack of appropriate services in the area of in the area of Pacific child, youth and family development).

Programmes aimed at improving the mental health of Pacific peoples need to be sited in places where Pacific peoples gather; historically, these have been the churches. Successive generations currently have the option of diverse experiences and outlooks on lifestyle.

There are several Pacific health pathways (as there are diverse cultural realities) for different Pacific peoples. Some ethnic Pacific models are being developed by the communities who work with them. Historically, in New Zealand a pan-Pacific approach has been applied to the way in which Pacific health issues are viewed and addressed. However, during the development of this strategy it was signalled that there is a need to address issues in a way that is relevant to each Pacific group. A Samoan model, Fonofale, is one option for some Pacific communities. The growing New Zealand-born Pacific populations may constitute another series of needs and considerations.

### Older Adults

The valuable role of older adults in society is often not acknowledged. Major life transitions take place at this stage – such as loss of work-related identity and income – and because of this, older adults can appear to have no real place in society. Roles can also change at this time. Many older adults become grandparents and many take on the role of caring for a partner. Another major issue faced by this group is loss and bereavement.

Older people need to be valued and have a recognised role in family/whānau/fono and community. The experience of older adults can be used in the community to the mutual benefit of all involved.

### Children & Youth

A review of the literature shows that providing children and youth with a solid developmental base and emotional support will improve their capacity for good mental health in adult years. This is particularly the case for the vital early years. For example, high quality pre-school daycare education improves the chance of being in well-paid employment over 20 years later. It also has beneficial effects on behavioural development and school achievement, lower teenage pregnancy

rates, higher socioeconomic status and decreased criminal behaviour (NHS Centre for Reviews and Dissemination 2000).

Long-term damaging effects of childhood 'stressors' (such as parental divorce, prolonged parental unemployment, frequent alcohol or drug use by parents) have strong associations with many aspects of adult mental health, including self-esteem, sense of coherence, and depression (Stephens 1998).

Raeburn (1999) reported upon the correlation between Canadian youth suicide rates and youth unemployment rates, concluding that maximum employment opportunities for the young and meaningful work for everyone are needed, and that youth unemployment needs to be regarded as a public health issue.

Preventive efforts are well researched in this area and have been shown to have the greatest impact among younger age groups because of the considerable potential, in young children, to improve long-term as well as short-term mental health (Raphael 2000). Greater preparedness is needed to ensure the kind of supportive environments in which young people can grow and learn, to provide effective education in personal and social competencies, and to identify and assess problems when they arise.

The Mental Health Commission's *Blueprint* recommends designated mental health specialists linking and supporting work with educational services, including early childhood and pre-school levels, to implement prevention services.

Mental health promotion programmes need to be delivered to children in the context of their families/whānau, schools and communities (e.g. support for family and whānau, especially in the vital early years). Equally important is the need for mental health promoters to work in partnership with educators to provide the most effective interventions for the promotion of mental health and wellbeing in children and youth.

# Appendix 2

## APPENDIX 2

### Mental Health Promotion Models

#### Population health model

Population health refers to the health of groups, families and communities. The population health model embraced by Public Health takes into account all factors that determine health.

'Populations' describe different groups of people defined by locality (e.g. country, town or suburb) biological criteria (age, ethnicity or gender), social criteria (socioeconomic status or disability), cultural criteria, (e.g. whānau) and their utilisation of services, such as a health practice population.

A population health model can be used by the whole of the health sector to influence the broad range of factors which determine health: peace, shelter, education, food, sufficient income, a stable ecosystem, sustainable resource use, social justice, equity (Ministry of Health 1998).

#### Community development model

This model is based on the premise that communities best understand their own needs and are best positioned to come together to resolve problems and promote healthy communities. It is primarily about 'building social cohesion, supportive environments, community ownership and control and unifying disadvantaged groups or those people excluded from participating in society (Raeburn and Corbett 2001).

#### Primary mental health care model

Activity under this approach recognises the services provided in settings currently covered under the scope of the Primary Health Care Strategy, with its emphasis on 'enrolled populations'. Besides general practice and primary health organisation services, mental health promotion interventions include those provided by school counsellors, nurse practitioners, midwives, voluntary groups, counselling agencies and self-support groups. It is important to note that families, communities and the voluntary efforts of community members who mobilise around common problems, are often the first point of contact and provide the main source of help for many people with problems.

#### Strengths-building model

The strengths model arose as an alternative to diagnostic-based social work approaches, which were often criticised as categorising people according to symptoms, ignoring critical environmental situations and ultimately blaming individuals for their disabilities. In contrast, the strengths perspective avoids blaming behaviour by focusing on identifying individual, family and community strengths (Russo 1998).

The philosophy behind this approach has three distinct elements.

First, rather than dwelling on what is wrong, on illness or deficit, it emphasises the resourcefulness and resilience that exists in everyone. The strengths approach recognises that all people have potential and capacity to grow, change and adapt. All people have capabilities, abilities, strengths, and the environments, that act on these qualities, include resources and opportunities that foster the development of those attributes and talents.

A second major philosophical emphasis of a strengths approach is that of the primacy of people and community. This includes a fundamental trust in people's own judgement about what is good for themselves, their families and their communities. The role of community (and community development) is especially emphasised here, because collective wisdom and collective support, and the building of group and community cohesion and strength, are believed to be optimal for improving overall health and wellbeing. At the heart of this is the belief that mental health is determined to a great extent by people's own sense of control over their lives.

The third element of a strength-building philosophy is the acknowledgement of the importance of both culture and society as determinants of our mental health and wellbeing. In New Zealand in particular, culture has been recognised as being of huge importance in human affairs, and its influence permeates every aspect of the lives of all of us. A full recognition and honouring of this reality is essential for the good mental health of all people. In addition, in the past, mental health often has been regarded as an 'internal' matter, as something that is caused by some deficiency within the person.

This often leads to people being 'blamed' and stigmatised for their suffering and mental afflictions. While acknowledging the role of genetic and personal factors, a strength building approach to mental health promotion also emphasises that the state of our society as a whole, and aspects such as the economy, socioeconomic status, housing, employment, education, and so on are vitally important for the overall mental health of our nation. This gives us cause for optimism, because these factors are potentially modifiable, which means we can hope for continuously improving mental health and wellbeing in the future as societal conditions improve under wise governance.

The perspective, for the most part, holds that people manage to survive, sometimes in the face of great challenges. An assumption of the strengths perspective is the idea that people are resilient. A growing body of evidence documenting resiliency includes characteristics such as **social competence** (e.g. ability to elicit positive responses from others), **autonomy** (e.g. a strong sense of independence and self-efficacy), and a **sense of purpose and future** (Early and GlenMaye 1998).

The approach supports the establishment of 'niches' or environmental conditions that enable rather than stigmatise individuals, which are focused on seeing possibilities rather than problems, options rather than constraints and wellness rather than sickness (Rapp 1998).

### Recovery model

Recovery is defined in the *Blueprint* (Mental Health Commission 1998) as the ability to live well in the presence or absence of one's mental illness. The definition is purposefully broad, acknowledging that the experience of recovery is different for everyone and a range of service models could potentially support recovery.

Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness, and when mental health services can develop people with mental illness and support their communities and families to interact with each other (Mental Health Commission 2000).

### Te Whare Tapa Whā

For Māori, the concepts of health and wellbeing go beyond physical wellbeing. Good health is recognised as being dependent on a balance of factors. Mason Durie's Whare Tapa Whā model of health (1994), describes four components, which represent the four walls of a house and the

idea that if one of these walls fails, the house will fall. Reflecting a Māori perspective of health, whare tapa wha includes consideration of:

**Te taha wairua** - spiritual health, including the practice of tikanga Māori in general.

**Te taha tinana** - the physical aspects of health.

**Te taha hinengaro** - the emotional and psychological wellbeing of the whānau and of each individual within it.

**Te taha whānau** - the social environment in which individuals live – the whānau of family, the communities in which whānau live and act.

In public health there are two other perspectives, which are seen as particularly important:

- **Te ao turoa** - the environment: the relationship between Māori and te ao turoa is one of tiakitanga (stewardship). It is the continuous flow of life source. Without the natural environment, the people cease to exist as Māori.
- **Te reo rangatira** expresses the values and beliefs of people and is a focus of identity. The root of all cultures is the language, and te reo is a vital expression of rangatiratanga (Ministry of Health 1996).

### Te Pae Mahutonga

Te Pae Mahutonga (Southern Cross Star Constellation) is a model of health that brings together determinants as they apply to Māori health. The model is presented in the shape of the Southern Cross. Four health promotion activities are represented by the four compass direction points and a further two pointers symbolising leadership and autonomy (Durie, cited in Briggs 2001).

Determinants	Promotion Activity	Determinants	Promotion Activity
<ul style="list-style-type: none"> <li>• Te Oranga (Participation in society).</li> </ul>	<ul style="list-style-type: none"> <li>• Affordable housing.</li> <li>• Favourable work conditions.</li> <li>• Quality education.</li> </ul>	<ul style="list-style-type: none"> <li>• Waiora (Physical environment).</li> </ul>	<ul style="list-style-type: none"> <li>• Clean environment.</li> <li>• Sustainable natural resources.</li> </ul>
<ul style="list-style-type: none"> <li>• Toiora (Healthy lifestyles).</li> </ul>	<ul style="list-style-type: none"> <li>• Fostering healthy child development.</li> <li>• Encouraging development of mental health protective factors.</li> </ul>	<ul style="list-style-type: none"> <li>• Mauriora (Cultural identity).</li> </ul>	<ul style="list-style-type: none"> <li>• Meeting the Crown's obligations to the Treaty of Waitangi.</li> <li>• All groups supported to participate in society.</li> <li>• Cultural diversity is valued.</li> </ul>
<ul style="list-style-type: none"> <li>• Ngā Manakura (Community leadership).</li> </ul>	<ul style="list-style-type: none"> <li>• Explore macro policy responses to reduce health inequalities.</li> <li>• Promote public and primary care approaches to mental health promotion.</li> <li>• Develop supportive communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Te Mana Whakahaere (Autonomy).</li> </ul>	<ul style="list-style-type: none"> <li>• Support for providers and their development to deliver health solutions for Māori.</li> <li>• Developing self-sufficiency.</li> </ul>

### Fonofale model of health

The model is based on a Samoan perspective of health. It describes health in terms of the fonofale (Mental Health Commission 2001), the traditional Samoan meeting house.

The roof represents the cultural values and beliefs that incorporate both traditional and western methods of healing. The foundation of the fonofale represents the nuclear as well as the extended family and symbolises the importance of family as the central point of social organisation. It is through the family structure that support is channelled to augment development in relation to the Samoan four dimensions of health: physical, spiritual, mental and social.

Surrounding the fonofale, at the centre of the model, are elements of the social context in which the health of Samoan people is best nurtured. These elements recognise the importance Samoan health in a New Zealand setting, the time period and environment (e.g. rural, urban).

# Appendix 3

## APPENDIX 3

Figure 5: **PROTECTIVE FACTORS** *potentially influencing the development of mental health problems and mental disorders in individuals (particularly children).*

Individual factors	Family/social factors	School Context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> <li>• Easy temperament.</li> <li>• Adequate nutrition.</li> <li>• Attachment to family.</li> <li>• Above-average intelligence.</li> <li>• School achievement.</li> <li>• Problem-solving skills.</li> <li>• Internal locus of control.</li> <li>• Social competence.</li> <li>• Social skills.</li> <li>• Good coping style.</li> <li>• Optimism.</li> <li>• Moral belief.</li> <li>• Values.</li> <li>• Positive self-related cognition.</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive caring parent.</li> <li>• Family harmony.</li> <li>• Secure and stable family.</li> <li>• Small family size.</li> <li>• More than two years between siblings.</li> <li>• Responsibility within the family (child or adult).</li> <li>• Supportive relationship with other adult (for a child or adult).</li> <li>• Strong family norms and morality.</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of belonging.</li> <li>• Positive school climate.</li> <li>• Prosocial peer group.</li> <li>• Required responsibility and helpfulness.</li> <li>• Opportunities for some success and recognition of achievement.</li> <li>• School norms against violence.</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement with significant other person (partner/mentor).</li> <li>• Availability of opportunities at critical turning points or major life transitions.</li> <li>• Economic security.</li> <li>• Good physical health.</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of connectedness.</li> <li>• Attachment to networks within the community.</li> <li>• Participation in church or other community group.</li> <li>• Strong cultural identity and ethnic pride.</li> <li>• Access to support services community/cultural norms against violence.</li> </ul>

Both figures 5 and 6 are reproduced from: Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Figure 6: **RISK FACTORS** *Potentially influencing the development of mental health problems and mental disorders in individuals (particularly children).*

Individual factors	Family/social factors	School Context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> <li>• Prenatal brain damage.</li> <li>• Prematurity.</li> <li>• Birth injury.</li> <li>• Low birth weight, birth complications.</li> <li>• Physical and intellectual disability.</li> <li>• Poor health in infancy.</li> <li>• Insecure attachment in infant/child.</li> <li>• Low intelligence.</li> <li>• Difficult temperament.</li> <li>• Chronic illness.</li> <li>• Poor social skills.</li> <li>• Low self-esteem.</li> <li>• Alienation.</li> <li>• Impulsivity.</li> </ul>	<ul style="list-style-type: none"> <li>• Having a teenage mother.</li> <li>• Having a single parent.</li> <li>• Absence of father in childhood.</li> <li>• Large family size.</li> <li>• Antisocial role models (in childhood).</li> <li>• Family violence and disharmony.</li> <li>• Marital discord in parents.</li> <li>• Poor supervision and monitoring of child.</li> <li>• Low parental involvement in child's activities.</li> <li>• Neglect in childhood</li> <li>• Long term parental unemployment.</li> <li>• Criminality in parent</li> <li>• Parental substance misuse.</li> <li>• Parental mental disorder.</li> <li>• Harsh or inconsistent discipline style.</li> <li>• Social isolation experiencing rejection lack of warmth and affection.</li> </ul>	<ul style="list-style-type: none"> <li>• Bullying.</li> <li>• Peer rejection.</li> <li>• Poor attachment to school.</li> <li>• Inadequate behaviour management.</li> <li>• Deviant peer group.</li> <li>• School failure.</li> </ul>	<ul style="list-style-type: none"> <li>• Physical, sexual and emotional abuse.</li> <li>• School transitions.</li> <li>• Divorce and family breakup.</li> <li>• Death of family member.</li> <li>• Physical illness/impairment.</li> <li>• Unemployment homelessness.</li> <li>• Incarceration.</li> <li>• Poverty/economic insecurity.</li> <li>• Job insecurity.</li> <li>• Unsatisfactory workplace relationships.</li> <li>• Workplace accident/injury.</li> <li>• Caring for someone with an illness/disability.</li> <li>• Living in nursing home or aged care hostel.</li> <li>• War or natural disasters.</li> </ul>	<ul style="list-style-type: none"> <li>• Socioeconomic disadvantage.</li> <li>• Social or cultural discrimination.</li> <li>• Isolation.</li> <li>• Neighbourhood violence and crime.</li> <li>• Population density and housing conditions.</li> <li>• lack of support service including transport, shopping, recreational facilities.</li> </ul>