

Building on Strengths: A Guide for Action

A New Approach
to Promoting Mental Health
in New Zealand/Aotearoa

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MANATŪ HAUORA

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Introduction

This document *Building on Strengths – A Guide for Action* complements the consultation document *Building on Strengths – A Springboard for Action*. It details the work signalled in the consultation document. Both documents have been developed by the public health group of the Ministry of Health,¹ in conjunction with a reference group.

A Guide for Action gives an overview of possible activities that can be picked up by a broad range of players – from District Health Boards to government agencies to groups in the community. It also summarises some interventions that have proven effective in other settings.

The over-riding theme of *Building on Strengths* is that there is already good work going on in this country. There are strengths in the community that simply need to be tapped and combined.

Various interested communities have already been involved in the process of developing this document through fono, hui and meetings. As well as the framework for this approach, models of service delivery, current issues, and priorities for future funding were explored.

Published research and best practice information around promotion and prevention have also informed this document and a stocktake of services with a mental health promotion or prevention component purchased through Vote:Health is included.²

Like the consultation document, the *Guide for Action* reflects the three key elements of this new approach to the promotion of mental health in this country – *creating healthy populations*, focusing on *wellness*, and the *community taking control*.

It is designed to be a practical, working document for service providers and communities to use and adapt to their own particular needs. It is also designed to stimulate government bodies and others to think about a more collaborative approach to good mental health.

The backbone of *Building on Strengths* is a huge body of work, contributions and animated debate that has taken place over the past year. With the addition of your ideas through consultation, a fleshed out *Guide for Action* will steer us towards a picture of improved mental health and well-being for the people of this country.

Additional copies of this document as well as copies of the consultation document can be ordered by contacting: Wickliffe Press, PO Box 932, Dunedin. Tel: (04) 496 2277 (Wellington), Fax: (03) 479 0979 (Dunedin), Email: moh@wickliffe.co.nz. Or visit the Ministry of Health's website at: www.moh.govt.nz – and look under publications.

¹ On behalf of the Ministry of Health public health and mental health Deputy Directors General.

² See Appendix One.

Process

Building on Strengths has been developed through contributions and animated debate that has taken place over the past year. The process to develop this document has been as important as the document itself. The reference group responsible for developing the strategy felt that the process should honour the principles of mental health promotion. An initial document was produced that was a synthesis of a wide range of perspectives and opinions gathered through meetings, fono, hui and presentations. This reference document represents a refinement of the original paper.

Guide for Action: Actions on Factors Affecting Mental Health

The following actions aim to address the wider factors that can affect mental health and wellbeing.

Building healthy communities

Rationale

This strategy recognises that mental health impacts on all health. Creating healthy communities (where individuals experience a sense of belonging, trust, participation and social support) promotes positive mental health (Leeder 1998; Berry and Rickwood 2000). VicHealth (1999) reported that social integration and social support is directly related to mental health status, illness in general and death. For example, young people who do not mix well socially are between two and three times more likely to experience depressive symptoms, compared with peers who have confiding relationships (Glover et al 1998). Social support was also found to be the single most powerful influence on wellbeing and lack of distress in the Canadian report *Population Mental Health in Canada* (Stephens 1998).

The international literature identifies four factors key to building strong communities: Participation, Resources, Leadership and Co-operation. Unhealthy communities are unable to build or maintain the physical and social infrastructure their members need to support each other and to realise their individual potential (Baum 1999).

Building on Strengths reflects the belief that to effect real change in the health and wellbeing of a community, the community itself must take control. The Ottawa charter has emphasised the fundamental importance of community involvement in health promotion. Community development programmes that address the wider factors affecting mental health have been identified as showing great potential (Shiell and Hawe 1996) and community development has also been explicitly included as a New Zealand Health Strategy objective.

It makes sense that the community is best placed to define its own problems and also to help address those problems. The job of the health funders, providers and policy makers is to support and encourage this process.

Guide for action

- Develop programmes and policies to enhance capacity of communities.
- Help Māori communities to come together to identify and solve problems in their communities.
- Encourage and support leadership in local communities, eg, mental health service user involvement in *Like Minds Like Mine* project and Māori Women's Welfare League.
- Promote successful community development projects.
- Provide opportunities for sharing information through effective networks.
- Investigate processes for sustainable funding for community development projects.
- Support co-ordination of activities at national and local levels to maximise their impact.
- Support community advocacy.

Building the research base

- Develop a body of research that links community development to better mental health outcomes, ie, what is the minimum required for community development processes.
- Establish benchmarks for sustainable funding for community processes and outcomes.
- Build the research base around indicators of problem-solving capabilities of communities.
- Support development of appropriate models of Māori community development and their evaluation, eg, *Ura Atu and Tipu Ora (1996)*, community action to reduce alcohol related traffic injury among Māori.

Outcomes

- Strong and cohesive communities, whānau and hapū, eg, improved problem solving capability of communities (ability to express collective views and exchange information, mechanisms for conflict containment and accommodation).
- Local participation in decision making.
- Well-resourced communities.
- Communities advocating for themselves and other members of the community.
- Safer communities.
- Visible community leadership.
- Increased social capital.
- Social inclusion.
- Communities working with and being supported by a range of sectors.

Working across sectors

Rationale

Work done in the health sector can go only part way to improving mental health. It is only when the health sector works with other government and non-government agencies in a co-ordinated fashion to address the wider factors affecting mental health, that real progress will be possible. Mental health promotion requires action in many sectors – health, employment, housing, education, environment, and social services, for instance, as well as non government or community based organisations (such as health support groups, marae, churches, clubs and other bodies). This section aims to establish infrastructures to encourage government and non-government agencies to support and address the broader determinants of mental health and wellbeing.

The National Mental Health Standards (18.3) (Ministry of Health 1997) require mental health services to provide information and work closely with mental health service user groups and other community groups around factors that prevent mental illness and mental health problems. To be able to do this effectively a cross-sectoral approach is required.

Collaborative health promotion and disease prevention by all sectors is one of the principles of the New Zealand Health Strategy.

Guide for action

- Consult and support different agencies and communities to identify action plans around mental health promotion.
- Develop a national framework for linking across sectors.
- Further develop existing networks to work with other government agencies, eg, ‘Strengthening Families’ project and the Youth Suicide Inter-Agency Committee.
- Distribute information on the relationship between mental health and wider determinants of mental health (eg, “healthy communities/cities”).
- Investigate innovative ways of engaging with local councils and other community groups.
- Support “healthy communities/cities” programmes.
- Promote mental health through supportive social and physical environments, eg, work with local authorities on child and youth advocacy.
- Encourage establishment of infrastructure to link communities to marae, education, hospital, etc.
- Research is shared across agencies and informs policy decisions.
- Support the prevention benchmark outlined in Mental Health Commission’s *Blueprint* for mental health services to liaise with other services and programmes to carry out prevention work.

Building the research base

- Develop a research base on the relationship between mental health and wider determinants of mental health.
- Develop a research base on the relationship between intersectoral co-operation and health outcome.
- Research organisational commitment in relation to capacity building.

Outcomes

- Mental health promotion is embraced by different agencies.
- Everyone sees mental health promotion as their business.
- A range of services which addresses needs and builds on strengths is available.
- Infrastructure across sectors is developed to implement strategy.
- Strong information base linking mental wellbeing to wider determinants of mental health.
- Accessible and effective interventions for Māori.
- Incentives for promoting mental health are provided.
- Strong and effective networks between and across organisations.
- Health sector policy informed by research.
- Research responsive to policy needs.

Improving skills of the workforce

Rationale

Building on Strengths aims to encourage participation in mental health promotion and prevention programmes from all players, eg, communities, marae, mental health workers, public health workers, and local government. A confident workforce with positive attitudes and beliefs is vital. It must have the necessary competencies and skills to work effectively with communities, families/whānau and individuals as required.

Effective implementation of promotion and prevention programmes will require an understanding of a population health approach by mental health services (Raphael, 2000). There is also considerable scope for primary health care workers to play a significant role in relation to mental health prevention, as they do in preventing physical illness (eg, smoking cessation advice, green prescription etc). This is consistent with the Primary Health Care Strategy (Ministry of Health, 2001) that emphasises the importance of education and prevention. This will require a team approach and some new skills within the workforce.

These groups require an analysis of their training needs and appropriate training opportunities to deliver components of this strategy. Public health has a role in facilitating this process as effective implementation of promotion and prevention requires an understanding of public health approaches, eg, epidemiology and building the capacity of staff in relation to a population health approach.

The disparity between Māori mental health status and that of non-Māori has a parallel in the under-representation of Māori in all disciplines of the health workforce. This is an area that requires further development in relation to mental health promotion and prevention.

Guide for action

- Identify components of current workforce and gaps in expertise and develop a workforce plan for the health workforce initially, with particular emphasis upon mental health specialists in relation to prevention work.
- Identify Māori involved in Mental Health Promotion and their training needs.
- Encourage dissemination of Te Pae Mahutonga for implementation and evaluation to guide Māori programme design.
- Work with relevant sectors and agencies to ensure a component on the broader determinants of mental health is in the curricula of health sector professionals at a national planning level.
- Encourage workforce and community to come together to network and share experiences and successes regarding mental health promotion and prevention.
- Encourage a multi-disciplinary approach in public health units, such as employment of psychologists.

- Primary care workforce to be up-skilled in the area of primary prevention and mental health literacy.³
- Support opportunities for training around Māori models of mental health promotion.
- Create career pathways for Māori in mental health promotion.

Building the research base

- Develop and evaluate training packages focusing on a mental health promotion approach.
- Develop and evaluate training packages focusing on a primary prevention approach for mental health specialists and primary care workforce.

Outcomes

- Larger workforce skilled and resourced in the delivery of mental health promotion and primary prevention programmes in a sustainable fashion.
- Workforce acknowledges/understands wider determinants of mental health.
- Effective networks for the workforce.
- Critical awareness and structural level analysis is evident.
- Interconnectedness of mental health to total wellbeing recognised by workforce.
- Energised workforce interested in participating in mental health promotion and prevention.
- Workforce is broadened and not professionally dominated.
- More Māori appropriate training.
- More Māori models visible in mainstream services.

³ Mental health literacy refers to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. It includes knowing how to seek mental health information, knowledge of risk factors and causes, and attitudes that promote recognition and appropriate help-seeking.

Leadership through policy

Rationale

Building on Strengths aims to ensure all policy work and implementation is oriented towards mental health promotion. National policies need to recognise and address broader issues affecting mental health of all sectors of society.

A Canadian report found a clear association between social status and health, both mental and physical. The reasons, although not clear, appear to be related to equity of distribution of income, which in turn is related to human capital (group membership and social trust) (Stephens 1998).

Guide for action

- Develop a process to assess mental health impacts of government decisions.
- Develop an ongoing process for developing and assessing mental health priorities.
- Encourage collaboration between academia, other government agencies, public health providers, mental health providers and community groups.
- Encourage community participation in policy development and planning.
- Support joint venture projects at a local level.
- Explore joint planning mechanisms with local authorities.
- Encourage strong links between research and policy.
- Develop policies in partnership with Māori.
- Empower Māori to develop specific policy responses, eg, alcohol-free marae.
- Consider mental health impact when developing policy on employment, education, social welfare, child abuse, refugees, and substance misuse.

Building the research base

- Develop ways of measuring the mental health impacts of Government policies across all sectors.
- Identify research agenda linking policy development to mental health outcomes.

Outcomes

- An implementation plan and funding mechanisms to implement *Building on Strengths* is developed.
- Policies developed to meet the needs of communities.
- Policies begin to address structural problems that negatively affect mental health.
- Effective leadership at all levels to support mental health policies.
- Self-determination is promoted and supported throughout New Zealand/Aotearoa.
- Mental health impact assessments undertaken.

Encourage research, innovation and development

Rationale

Building on Strengths aims to ensure actions are based on best available information and to enhance the available body of knowledge/evidence around mental health promotion and prevention activities. It is also designed to be an educative tool, giving guidance about 'what works' and best practice in the area of mental health promotion and prevention.

The evidence reviewed during the development of this strategy was more focused on preventive approaches. The evidence to support the promotional end of the continuum is less developed, but showing promise.

Building on Strengths also aims to encourage and support evaluation and research in the area of mental health promotion and encourage piloting/innovation where research is currently being developed.

Guide for action and building the research base

- Work with health research agencies, District Health Boards and communities to develop a research agenda for mental health promotion.
- Identify research and gaps from different agencies with mental health and develop a co-ordinated approach to sharing and disseminating information.
- Develop a set of mental health and wellbeing indicators that tells us about mental health status of the population and helps track improvements of status over time.
- Develop a set of Māori mental health indicators.
- Ensure communities have access to research data on what works.
- Create opportunities for further discussion around ethnic-based models for Pacific peoples.
- Encourage good evaluation at all levels and feed into quality improvement, eg, all new implementation trials to have an evaluation component.
- Support health promotion research at a local level.
- Support networks between academics, practitioners, communities and policy makers.
- Further develop opportunities to discuss models of mental health promotion in New Zealand context, ie, Te Pae Mahutonga.⁴

⁴ Te Pae Mahutonga is described on page 19.

Outcomes

- Research agenda identified which is responsive to needs of the community.
- Increased body of research that is New Zealand specific.
- Research and indicators that are relevant to Māori and Pacific peoples.
- Kaupapa Māori research encouraged.
- Mental health indicators developed and process to monitor changes.
- Increased number of pilot projects with a health promotion focus where research basis is currently unavailable. This would include an evaluation component.
- Improved collaboration between research community and practitioners.
- Quality research that supports health promotion in action.
- Health promotion practitioner.

Guide for Action: Population Groups

The following actions propose mental health promotion and prevention activities specific to different population groups.

Groups experiencing disadvantage

Rationale

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, make it more difficult for people to maintain good mental health. This relates not only to the direct stress of poverty but also to the stress of being powerless to change this. 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).

Most epidemiological studies have found clear correlations between most forms of psychopathology and one or more of the following:

- emotionally damaging infant and childhood experiences
- poverty and degrading life experiences
- powerlessness and low self-esteem
- loneliness, social isolation and social marginalisation (Albee 1986).

It is common for families/whānau to experience many difficulties at the same time (Rutter and Quinton 1984). 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. And 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.

An improvement in health status of those currently disadvantaged is a principle in the New Zealand Health Strategy.

Guide for action

- Identify key workforce working with disadvantaged groups and develop national forum to raise issues, eg, ensuring adequate income levels for low-income pregnant women at risk of adverse birth outcomes.
- Encourage community development approach.
- Facilitate networking opportunities for workforce working with disadvantaged groups.
- Encourage and support local initiatives related to “Healthy Cities/Communities”.
- Health sector work with local councils to develop joint planning mechanisms for low income groups.
- Encourage further implementation of “Health Promoting Schools” in low decile schools.

Building the research base

- Research into options to improve social and economic advantage (building upon the research base of the relationship between disadvantage and poor health outcomes).
- Research the impact of improved mental health literacy for groups experiencing disadvantage.

Evidence-based health interventions

The following are examples of interventions that have proved effective for groups experiencing disadvantage (taken from systematic reviews of the evidence).

Infants and children

- Affordable high quality preschool education for children at risk (Health Funding Authority, Mental Health Operating Group).
- Parenting programmes for families at risk and single mothers (York University 1997).
- Home visiting programmes for parents with infants that offer support and connection to resources (Health Funding Authority, Mental Health Operating Group; Hodgson et al 1996; Wilson 1999).
- Anti-bullying programmes (Cowen 1994).
- Programmes to improve the psychosocial and cognitive development of babies and infants by focusing on interaction of parents, especially mothers living in conditions of stress and social adversity (WHO 1999).
- Home-based social support for socially disadvantaged mothers has shown slight decrease in injuries to children and may contribute to decreased child abuse and neglect and associated mental sequelae (NHS Centre for Reviews and Dissemination 2000).

Adolescents

- Resiliency programmes for adolescents (Health Funding Authority, Mental Health Operating Group).
- Home-based parenting schemes for teenage parents (Tilford et al 1997).

Adults

- Job search and problem solving skills for recently unemployed people (Tilford et al 1997; York University 1997).
- Support visits for new parents can improve mental health in children and adults in disadvantaged communities (NHS Centre for Reviews and Dissemination 2000).

Refugees

- To develop school curricula to promote multicultural understanding and tolerance (Abbott 1997).
- Improve access to language courses and trades/professions (Abbott 1997).
- Broadening the definition of family/whānau for purposes of admission in order to increase available support systems (Abbott 1997).
- Increasing public awareness of the possible difficulties faced by newcomers and the effects of prejudice on both victim and perpetrator (Abbott 1997).
- Public education to increase knowledge of, and acceptance of, the benefits of pluralism to society and of the contribution of newcomers to the cultural and economic life of the country (Abbott 1997).
- Refugee torture and trauma survivor strategies.
- Family/whānau reunification, access to interpreters, cultural induction and training and employment opportunities (Christchurch City Council 1997).

Community

- Community-based anti-violence programmes.
- Making GPs and other primary care professionals aware of risk status of high-risk groups (NHS Centre for Reviews and Dissemination 2000).

Outcomes

- Reduce discrimination experienced by disadvantaged groups.
- Improved resiliency of communities and individuals to cope with adverse life events.
- Improved mental health literacy.
- Stronger local and national response to “Healthy Cities/Communities” programmes.
- Less depression in particular groups.

Mental health service users/tangata whai ora

Rationale

One of the principles of the New Zealand Health Strategy is to promote 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. 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* makes it clear that "a discrimination-free environment is necessary if the Government's Mental Health Strategy is to be implemented" (MHC 1998, p.19). A public health programme to achieve this goal – the Project to Counter Stigma and Discrimination Associated with Mental Illness – has been underway since 1997. The project, under the brand name *Like Minds, Like Mine*, provides an example of how service users/tangata whai ora can be involved in the planning, delivery and implementation of mental health promotion programmes.

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

Guide for action

- Enhance and support participation of service users/tangata whai ora in promotion and primary prevention and partnership in the development and delivery of programmes.
- Enhance understanding of mental health promotion and primary prevention for mental health services users.
- Support children of parents with a mental disorder through promotion and primary prevention programmes.
- Ensure participation of mental health service users in policy development.
- Continue to work to eliminate stigma and discrimination associated with mental illness.

Building the research base

- Research effective approaches for promoting wellbeing amongst service users/tangata whai ora.
- Research into coping skills, social interactions and healthy environments for service users/tangata whai ora.
- Trial and evaluate job-search programmes for consumers.
- Research effective interventions for substance abuse.

Evidence-based health interventions

- Programmes focusing on motivation to change can ameliorate some alcohol-related problems through brief interventions (Health Education Authority 1997) development of coping skills, social relationships or meaningful activities (Hodgson et al 1996)
- Decrease discrimination (Disley 1997).
- Psycho-social interventions to help prevent relapse (Hodgson et al 1996).
- Supported employment in normal working environment for those recovering from mental illness is effective at keeping people in employment (NHS Centre for Reviews and Dissemination 2000).

Outcomes

- Mental health service users are more involved in the development of mental health policy.
- Mental health service users are actively involved in programmes to prevent mental illness and promote mental health.
- Mental health service users experience less discrimination, violence and abuse.

Māori

Rationale

Building on Strengths outlines action that aims to reduce the disparities in mental health experienced by Māori. To ensure that the strategies are delivered in a manner that is relevant to Māori, Professor Mason Durie has developed a framework for Māori health promotion – Te Pae Mahutonga (the Southern Cross).

In the Māori view of health, mental health is one of the four cornerstones of health and is not seen separately or as less important. The four cornerstones or dimensions that contribute to health and wellbeing are:

- te taha wairua (spiritual aspects)
- te taha hinengaro (mental and emotional aspects)
- te taha whānau (family and community aspects)
- te taha tinana (physical aspects).

Te Pae Mahutonga (the Southern Cross) symbolically maps out the significant components of health promotion as they relate to Māori health. There are four central stars representing:

- access to te ao Māori Mauriora
- environmental protection Waiora
- healthy lifestyles Toiora
- participation in society Te Oranga

and the two pointers of leadership (Nga Manukura) and autonomy (Te Mana Whakahaere).⁵

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.

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. A goal set in the strategy is around 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.

⁵ See Appendix 2 for a practical example of Te Pae Mahutonga.

Guide for Action

Mauriora (access to te ao Māori)

- Improved access to language and knowledge.
- Improved access to culture and cultural institutions.
- Improved access to Māori economic resources, such as land, forests and fisheries.
- Improved access to social resources such as whānau, Māori services, networks.
- Improved access to societal domains where being Māori is facilitated, not hindered.

Te Oranga (participation in society)

- Encourage active participation in the economy.
- Ensuring access for participation in education.
- Improve access to real employment.
- Support participation in the knowledge society.
- Facilitate participation in decision making.

Waiora (environmental protection)

- Acknowledge link between environment and mental wellbeing.
- Work to improve physical environment.
- Increase opportunities to access green/leisure spaces.
- Encourage research linking waiora and mental health.

Toiora (healthy lifestyles)

- Increase the evidence base for what has been successful for Māori.
- Link in with harm minimisation strategies, eg, drug and alcohol messages.
- Targeted interventions.
- Reduce exposure to risk factors.
- Ensure programmes and messages are culturally relevant.

Whakahaere (autonomy)

- Tino rangatiratanga is promoted and supported throughout New Zealand.
- Recognition of community group's aspirations.
- Encourage Māori capacity for self-governance.
- Support capacity building initiatives for Māori communities.

Manukura (leadership)

- Support community leadership.
- Encourage Māori health leadership.
- Support tribal leadership.
- Encourage alliances between leaders and groups.

Building the research base

- Develop appropriate methodologies to build a research base.
- Improve evidence base supporting effective interventions for Māori.
- Further develop Māori research and evaluation.
- Māori are involved in defining and determining measures and indicators for mental health and wellbeing.

Evidence-based health interventions

- Raukura Hauora o Tainui primary medical care clinics has a focus on bringing services to the people in their own environment. Success in Raukura Hauora o Tainui services can be measured in a number of ways, but evaluations of the immunisation rate for all eligible children on Te Paea Marae was audited at 90 percent.
- Kokona Whānau, a marae-based programme which addresses sexual abuse within the whānau.
- Rapua to Oranga Hauora, a community-based iwi-controlled service for Māori who have experienced mental illness. This service uses tikanga Māori as its guiding principle.
- Tipu Ora is an holistic well-child care programme which focuses on delivering health care programmes for parents, caregivers and tamariki.
- Whare Oranga are marae-based gymnasiums which use the institution of the marae to advocate lifestyle choices based on exercise and nutrition.
- Tihei Mauriora – smokefree marae.
- Ta Kohanga Reo Trust.

Outcomes

- Māori models of health promotion are visible.
- Māori communities determining their own solutions.
- Active participation at all levels for Māori.
- Māori see a positive future for themselves.
- Equitable access to opportunities, ie, employment, health.
- Improved capacity for self-governance.
- Increase in Māori workforce and leadership.
- Māori mental health indicators developed based on Te Pae Mahutonga.
- Healthier Māori communities.
- Programmes accessible and appropriate for Māori.

Pacific peoples

Rationale

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

In general there is a lack of research around Pacific peoples' mental health within the New Zealand context (Bathgate and Pulotu-Endemann 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. Another category was around absence of information and data on substance misuse.

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.

The translation of 'mental health' within Pacific worldviews is a conceptual problem because Pacific people perceive 'normality and what is not normal' from within different social constructs and meaning systems.

Programmes aimed at improving the mental health of Pacific peoples need to be sited in places where Pacific people 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 the direction that was signalled from Pacific communities was for further development along the lines of Pacific ethnic specific services. A Samoan model, Fonofale,⁶ is described in Appendix 3 as one option for some Pacific communities.

The New Zealand Health Strategy and the Pacific Peoples Health and Disability Action Plan support the principles of quality at all levels of health service development and implementation for Pacific peoples. These include issues of improved access, Pacific provider development, Pacific workforce development, public health programmes, cultural and clinical competencies for Pacific specific and mainstream providers, community based services, research and knowledge development.

⁶ The Fonofale model was developed by Karl Pulotu-Endemann.

Guide for action

- Support production of ethnic specific resources on mental health promotion and primary prevention.
- Support existing national networks with pan-Pacific groups in mental health promotion as well as Pacific ethnic-based networking.
- Develop a workforce development plan to meet the needs of Pacific peoples at all levels of mental health promotion and prevention.
- Support the involvement of Pacific representation in the decision-making processes related to planning, monitoring and evaluating.
- Support the development of information related to drug and alcohol, violence, gambling etc, in the language and medium appropriate to a range and diversity of Pacific populations.
- Support and assist programmes that will lead to changes in behaviour that minimise risks for mental wellbeing, eg, drug and alcohol misuse, parenting skills, gambling, activity levels, including physical activity, amongst elders.
- Support programmes that strengthen Pacific families.
- Support forums that enable Pacific peoples and their families to gather for planning purposes.

Responsiveness of mainstream

- Encourage responsiveness of mainstream services to the needs of different Pacific communities.
- Ensure cultural safety.
- Develop strategic alliances with Pacific-based providers.
- Make a Pacific difference in mainstream.
- Recruitment and workforce development for Pacific workers in mainstream.
- Utilise appropriate evaluation and monitoring systems.
- Develop pathways to Pacific communities at all levels to ensure Pacific community involvement.
- Include Pacific input into policy implementation and monitoring.

Building the research base

- Support research that identifies successful models of health promotion activities that meets the needs of a diverse range of Pacific populations and their attendant settings.
- Trial and evaluate new initiatives for Pacific peoples.
- Develop appropriate tools that evaluate initiatives for Pacific peoples.
- Support the development of a Pacific research workforce in mental health.

- Identify cultural beliefs and requirements of all the different groups within the Pacific population that impinge on mental health and wellbeing.
- Develop research around prevention of depression, and drug and alcohol misuse, within a Pacific context.
- Improve collation, analysis of data.⁷

Evidence-based health interventions

- Utilise traditional and contemporary forums of information sharing and decision making that are conducive to the needs of Pacific families (eg, churches, fono, extended family/aiga networks) and New Zealand settings such as (trusts, resource centres, schools, sports clubs, radio, TV) for mental health promotion work (Ministry of Health 1997).
- Beliefs shape the way Pacific people respond to mental illness and wellness (HFA 2000) and needs to be taken into account when designing programmes.
- Knowledge and information that is based on traditional lore and that is used to underpin 'cultural models' needs to have integrity and meet requirements of ethical scrutiny.

Outcomes

- Increase Pacific peoples workforce which delivers mental health promotion programmes.
- Support development of Pacific elder and youth leadership in mental health.
- Support evidence-based research to inform design, development and delivery, evaluation of Pacific initiatives.
- Ethnic-based models for mental health promotion are factually accurate, are of high quality and are developed and implemented in a way that does not harm Pacific peoples.
- Strong cultural identity and kinship/community ties.
- Pacific peoples have access to quality information.

⁷ This is consistent with the Pacific Action Plan: Priority Action Area 4, Pacific health information and research.

Children and youth

Rationale

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. For example, high quality preschool 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 is 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 preschool levels to implement prevention services.

Guide for action

- Children and young people to be at the heart of processes of promoting mental wellbeing.
- Develop training packages for public health practitioners, health workers and others, pertaining to the mental health of children and young people.
- Encourage publication of Māori/other mental health impact assessment reports on policies of government agencies who impact on child and youth, eg, Child, Youth & Family Services, Special Education Services, Department of Work & Income.
- Support access to te ao Māori, eg, Kohanga Reo Trust.
- Develop indicators appropriate for Māori and others around tamariki and rangatahi wellbeing.
- Support the "Health Promoting Schools" programme.

- Work with local councils to promote child friendly communities and youth forums, including supportive networks for parents and young people, eg, Icebreakers.
- Promote mental health through co-ordinated local action, eg, Youth Mental Health Forums.
- Education around mental health to be included in basic and further education of those who work with children and young people.
- Support and enhance programmes to support children experiencing traumatic life events.
- Continue to implement actions from the New Zealand youth suicide strategy.

Building the research base

- Investigate intervention programmes for substance misuse prevention in young people.

Evidence-based health interventions

Infancy

- Good preschool experiences and programmes (Raeburn 1995; Hodgson et al 1996; NHS Centre for Reviews and Dissemination 2000).
- Caregiver–child attachment programmes (Cowen 1994, Hodgson, et al 1996; Health Funding Authority, Mental Health Operating Group)
- Professionally-led parental empowerment groups promote positive parenting styles over time – children under six years of age (NHS Centre for Reviews and Dissemination 2000).
- Antenatal and early childhood interventions (Wilson 1999).
- Childhood immunisation (Mrazek and Haggerty 1994).

Childhood

- Healthy schools approaches have demonstrated that multi-faceted approaches are more likely to be most effective in terms of school health promotion initiatives (NHS Centre for Reviews and Dissemination 2000; Health Funding Authority, Mental Health Operating Group; Durlak and Wells 1997; Raeburn and Sidaway 1995).
- Life skills approach focusing on problem-solving, critical thinking, communication, interpersonal skills, empathy, and methods to cope with emotions (WHO 1999; Health Funding Authority, Mental Health Operating Group; Tilford et al 1997).
- Child-friendly schools to promote sound psychosocial environment in school to complement life skills approach (WHO 1999).
- Child acquisition of early, stage-salient competencies (Cowen 1994).
- Creating influential wellness-enhancing environments, eg, schools (Cowen 1994).

- Anti-bullying programmes (Raeburn and Sidaway 1995; Cowen 1994).
- Programmes for school-age children in high risk situations/environments that attempt to help children negotiate stressful transitions, eg, programmes for children of divorce or bereavement (Hodgson et al 1996; Tilford et al 1997; Durlak and Wells 1997; Health Funding Authority, Mental Health Operating Group; NHS Centre for Reviews and Dissemination 2000).
- Learning to cope effectively with stressful life conditions (Cowen 1994).
- Developing sense of empowerment ie, being in control of one's fate (Cowen 1994).

Adolescence

- Peer education programmes related to positive life skills (Mrazek and Haggerty 1994; Raeburn and Sidaway 1995).
- Programmes that promote reduced substance use by peers and that teach skills to resist social influences to alcohol and drugs (Mrazek and Haggerty 1994; Health Funding Authority, Mental Health Operating Group).
- Healthy schools approaches that encourage schools to provide more supportive environments for young people, enhanced academic, cognitive and social learning opportunities (Mrazek and Haggerty 1994; Health Funding Authority, Mental Health Operating Group).
- Violence reduction programmes (Mrazek and Haggerty 1994; Nicholas and Broadstock 1999).
- Restricting access to alcohol and other substances to young people (Mrazek and Haggerty 1994).
- Suicide prevention⁸ (Mrazek and Haggerty 1994; Wilson 1999).
- Prevention of depression (Nicholas and Broadstock 1999).

Outcomes

- Children with stronger identity, eg, cultural.
- Creating healthy communities where children are valued and have a voice.
- Health promoting environments for children and youth.

⁸ The Ministry of Youth Affairs is responsible for co-ordinating the implementation of the Youth Suicide Strategy, 'In Our Hands, New Zealand Youth Suicide Prevention Strategy/Kia Piki Te Or O Te Taitamariki, Strengthening Youth Wellbeing'.

Adults

Rationale

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 child bearing 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) has been shown as being 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, eg, those designed for adults experiencing divorce and bereavement (eg, Raphael 1977).

Guide for action

- Pilot workplace initiatives and policies with an evaluation component.
- Pilot job search programmes within the New Zealand context, with different approaches for recently unemployed people and long-term unemployed people.
- Encourage joint initiatives between health and housing to ensure adequate, affordable housing is available, work with key health sector providers (emergency departments, GPs, social workers, midwives) to stimulate further prevention-oriented action, eg, home support/home visiting during pregnancy to prevent depression).
- Encourage social support network building, especially for first-time mothers.
- Support programmes for adults undergoing stressful life transitions, eg, divorce or bereavement.
- Support programmes for adults experiencing trauma, ie, violence and abuse.
- Programmes aimed at supporting women during and after pregnancy.

Building the research base

- Build up a body of knowledge for New Zealand on what constitutes a mentally healthy person.
- Pilot and evaluate health at work policies for the health sector which address mental health and wellbeing.
- Trial community development approaches in an action research framework.
- Research into promoting good mental health through the media and links between media and violence.
- Research the mental health needs and effective programmes for refugees.
- Investigation of population-based approaches to abuse and violence problems.
- Investigate stress management interventions using population-based strategies.

Evidence-based health interventions

General

- Self-help/mental aid/social support groups and networks (Raeburn and Sidaway 1995).
- General health promotion programmes (Tilford et al 1997).
- Community development approaches (Raeburn and Sidaway 1995).
- Preparation for life transitions (Tilford et al 1997).
- Interventions to assist those who are at risk of depression although not currently diagnosed.
- Small group approaches to stress management (Raeburn and Sidaway 1995).
- Coping skills and support to newly separated people can improve mental health over the long term (Hodgson et al 1996; University of York 1997; NHS Centre for Reviews and Dissemination 2000).
- Regular exercise can decrease mental illness and aerobic exercise is associated with a decrease in anxiety (NHS Centre for Reviews 2000).

Work related

- Workplace programmes and policies – organisation-wide approaches (WHO 1999; Raeburn and Sidaway 1995; Van der Hek and Plomp 1997).
- Job search and problem-solving skills for unemployed adults and vocational training and programs to create jobs (Tilford et al 1997; WHO 1999; University of York 1997; Raeburn and Sidaway 1995; NHS Centre for Reviews and Dissemination 2000).
- Occupational stress reduction and enhanced stress coping skills programmes for those who work in stressful occupations.

Carers

- Programmes for those in a long-term caring role, eg, those caring for an older, ill or disabled person (respite care and psycho-social support) (Tilford et al 1997; University of York 1997).
- Programmes which address needs of long term carers of people who are highly-dependent, eg, respite care, training in assertiveness and coping skills (Tilford et al 1997; University of York 1997; NHS Centre for Reviews and Dissemination 2000).

Pregnancy

- Support during pregnancy and labour from trained lay women can improve obstetric and mental outcomes (University of York 1997; NHS Centre for Reviews and Dissemination 2000).
- Multiple community agency home visiting programmes for prenatal or postnatal women and babies promotes factors associated with bonding and positive child development (NHS Centre for Reviews and Dissemination 2000).
- Professional emotional support of pregnant women caring for additional young children can decrease rates of postnatal depression (NHS Centre for Reviews and Dissemination 2000).
- Support and coping skills for new mothers (Hodgson et al 1996; Tilford et al 1997).
- Home visiting before and after childbirth can improve mental wellbeing of mother and child and decrease depression (NHS Centre for Reviews and Dissemination 2000).

Outcomes

- Reduced workplace stress and related sickness claims.
- All adults having access to structures and institutions that support full participation in society.
- Emotional, physical, spiritual, cultural and mental safety assured.
- Strong individuals and cohesive families.
- Good parenting practices widely supported and facilitated.
- Decreased levels of postnatal depression.
- Increased level of community development programmes evident.
- Improved maternal health.

Older adults

Rationale

Older adults have a valuable place and role in society, one which is often not acknowledged due to the life transitions that take place at this stage in life, eg, loss of work-related identity and income. Maintaining meaningful roles and finding new social roles that give life meaning constitute an important and often ignored developmental task.

Roles change and many older adults take on a caring role and become grandparents. Another major issue is coping with loss and bereavement.

Guide for action

- Encourage transition programmes led by peers and programmes promoting healthy ageing.
- Develop mechanisms for older adults to contribute fully to their communities, including mobilisation strategies in lifestyle programmes.
- Ensure strong social networks.
- Implement effective prevention programmes for those at high-risk, such as older adults having recently been bereaved.
- Ensure that adult interventions are responsive to older people who may wish to access them.
- Enhance opportunities for older adults to continue to contribute in a workplace and other environments.

Building the research base

- Build up a body of knowledge around effective prevention and promotion initiatives for older adults.
- Disseminate the research base to relevant organisations.
- Research into positive ageing.
- Investigate exercise programmes and the impact on mental health of older adults.

Evidence-based health interventions

- Mobilisation in lifestyle and similar programmes at the community level (Raeburn and Sidaway 1995).
- Supportive interventions for the recently bereaved (Tilford et al 1997).
- Exercise programmes linked to mental health outcomes (Tilford et al 1997; NHS Centre for Reviews and Dissemination 2000) and linked to decreased stress levels (King et al 1993; NHS Centre for Reviews and Dissemination 2000).
- Improvements in quality of life for those reaching older age, eg, active ageing programmes, by promoting older persons' rights and aspirations (WHO 1999).
- Older people who volunteer can enhance their sense of wellbeing. Most older people who receive services from an older volunteer (eg, peer counselling of nursing home residents) are less depressed than those in similar circumstances who do not (NHS Centre for Reviews and Dissemination 2000).
- Variety of mutual self-help support groups.

Outcomes

- Leadership role of older people is more visible and valued.
- Increased opportunities for older persons to participate in exercise programmes linked to good mental health outcomes.
- More programmes running for positive ageing and transition into retirement.
- More positive representation of ageing in communities.
- Increased social support for older adults.
- Decreased incidence and prevalence of depression and anxiety for older adults.

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Appendix One: Report on Stocktake of Mental Health Promotion and Primary Prevention Activities: A Summary

The following is an executive summary of the stocktake⁹ conducted to identify current mental health promotion/primary prevention initiatives.

Information from a stocktake of Vote:Health-funded mental health promotion/primary prevention initiatives, including youth suicide prevention, is to be used to facilitate strategy development and provide a firmer basis for assessing future priorities. Health sector restructuring is occurring. Much of the information came from the Health Funding Authority, as it was then the purchaser of most of the services. Other information was from the Ministry of Health. There may be some omissions and some duplications in the stocktake, given the variety of information sources and ways of recording information, but it is important to document the material and move on to refine it as the strategy is developed and implemented.

The stocktake list has been ordered in three sections:

- mental health promotion/primary prevention activities
- youth suicide prevention activities
- services which impact on them.

Respondents' comments on service gaps included suggestions about suicide-related needs and a suggestion that mental health service user involvement be strengthened in the project for countering stigma and discrimination. It was also suggested that the Family Start/Early Start programme, now in 17 locations, could be useful in other parts of the country where children are at-risk.

Suggestions for immediate and longer-term priorities included that the mental health of Māori, Pacific people, children and youth should be addressed first because they have the greatest degree of disadvantage and inequity. Others comments included the place of information provision as a key priority, and the desirability of continuing the Māori strategy for mental health and wellbeing, and extending it to Pacific communities.

Main issues facing service development were thought to be getting sufficient funding, giving mental health teams a mandate and funding for promotion/prevention work, and dealing with changes arising through restructuring the health sector, so that there will be unity of direction and priorities.

⁹ A separate report for the full stocktake of mental health promotion/primary prevention initiatives is available.

Many of the activities are directed to the general population. Children's needs are addressed sometimes in the context of families and sometimes in the context of school. Youth, or "children and youth" are the focus of the biggest proportion of the remaining activities, due in large measure to the "One Stop Shop" initiatives and the "Health Promoting Schools" initiatives.

There were few activities reported in the stocktake that focused on older adults and few on 0–5 year olds.

Most of the initiatives would fall into the following clusters, with some overlaps.

- *Like Minds Like Mine*
- promotion/prevention – mostly aspects of violence/abuse, sexual health and drug related behaviours
- Māori promotion/prevention
- suicide
- child/youth health
- information and evaluation.

Services which impact on the initiatives would mostly fall into the following main clusters.

- Training for informal carers (largely done by "other").
- Violence or abuse (largely done by "other").
- Family Start/Early Start (largely done by "other").
- One Stop Shop (largely done by "other").
- Child health (few in number and 3 to 1 by "other").
- Healthy schools (more by Hospital Health Services than by "other").
- Sexual health contracts (about evenly divided between Hospital Health Services and "other").
- Alcohol and drug (evenly divided).

The stocktake has shown variations in activities. Some may be "gaps" but they would need to be related to populations and their needs to assess this, a separate task. The most obvious variations are to do with age, with few activities focused on older adults and few on 0–5 year-olds. Geographical coverage seemed variable and would need to be assessed against population characteristics. There were few references to evaluations other than for the Tu Tangata programme and the *Like Minds Like Mine* programme.

Appendix Two: Te Pae Mahutonga

Note: The following are examples of how to operationalise Te Pae Mahutonga using accommodation as an example.

	Whakahaere	Manukura	Mauriora	Te Oranga	Waiora	Toiora
Local	Control	Community leadership	Access to language and knowledge	Participation in economy	Water free from pollutants	Harm minimisation
Regional	Recognition of group aspirations	Health leadership	Access to culture and cultural institutions	Participation in education	Clear air	Targeted interventions
	Relevant processes	Tribal leadership	Access to Māori economic resources such as land, forests and fisheries	Participation in employment	Earth abundant in vegetation	Risk management
National	Sensible measures and indicators	Communication	Access to social resources such as whānau, Māori services, networks	Participation in knowledge society	Healthy noise levels	Cultural relevance
	Impact assessments of Government policies	Alliances between leaders and groups	Access to societal domains where being Māori is facilitated not hindered	Participation in decision making	Opportunities to experience the natural environment	Positive development
	Intersectoral synergies					
	Capacity for self-governance					

	Whakahaere	Manukura	Mauriora	Te Oranga	Waiora	Toiora
Individual	Accommodation providers assist tangata whai ora to define their needs and then support them to achieve their goals and ambitions, eg, tangata whai ora designing their lifestyle plans.	Accommodation provider staff actively promote a healthy lifestyle through their interactions with tangata whai ora.	Accommodation providers engage with kaupapa Māori initiatives and programmes that assist tangata whai ora to access te ao Māori, such as kapa haka, Raranga, Te reo classes, Māori art, drama and media, eg, Mana, Tumai.	Accommodation providers ensure that there is access to good information relating to good health, eg, accommodation providers assisting tangata whai ora to access information and participate in relevant programmes connected to but not limited to lifestyle plans.	A healthy environment is promoted and demonstrated, eg, maintaining a clear and healthy 'home' may be broken into development plan for tangata whai ora such as house cleaning responsibilities. Trips to environments, eg, ngahere, moana, maybe proactive cleaning trips, eg, 'ostrich parades'.	A healthy lifestyle is actively promoted and developed based on individual needs, eg, lifestyle plan that may set goals and opportunities for tangata whai ora. Plan could also include resources provided by accommodation providers.
Whānau in this context refers to two particular realities: <ul style="list-style-type: none"> whānau by association, eg, living in the same house whakapapa. 	Whānau are supported and assisted to determine their development and wellness as a whānau.	Whānau have access to leadership and direction through Kaumatua and support staff to assist them. Whānau leadership is encouraged in the overall care and support of their whānau member.	Whānau as a collective supported to access their own identities and to develop their own identity as a collective. Whānau encouraged and supported to involve tangata whai ora in whānau activities and support tangata whai ora journey, eg, kaumatua.	Whānau concept developed and embraced in communal setting whānau network developed to support individual tangata whai ora. Whānau encouraged to participate in whānau member's care and development. Whānau regularly updated.	Whānau trips to ngahere, moana etc supported by providers. Whānau welcome and encouraged to visit whānau members. Tangata whai ora supported to participate in whānau activities – hui, tangi etc.	Whānau as a whole develop a lifestyle plan for their home, eg, if smokers smoke outside. Whānau informed and educated as to tangata whai ora developments.

	Whakahaere	Manukura	Mauriora	Te Oranga	Waiora	Toiora
Local	Hapū solutions for hapū issues. A collective approach for a collective gain. Appropriate resource allocation reflective of the work.	Leaders/managers of supported accommodation and Māori providers trained to effectively lead and promote the development and provided with leadership opportunities.	Further local development of kaupapa Māori services to assist Māori to access a range of activities and services in te ao Māori that assist in attaining and developing a identity.	Marae supported to assist whānau through proactive strategies promoting participation of whānau whanui and i a hapū i a hapū.	District Health Boards and local government to work together to actively promote a healthy environment. Town planners and resource consent processes to consider placement of supported accommodation in reference to access to natural environment.	District Hospital Boards ensure the development and maintenance of programmes that actively promote and support whānau and individuals to access healthy lifestyle opportunities and resource using Māori providers to deliver Māori managers.
Regional	Māori providers are supported in their development to deliver and promote Māori quality management of Māori issues.	Leadership supported and encouraged at kura, marae, eg, young Māori leader forums, kaupapa Māori leadership wananga developed.	Regional development to ensure access ki te ao Māori is consistently available increase access.	Active participation encouraged through regional consultation processes that encourage and continue community development.	Regional campaigns to keep Aotearoa Ataahua. Aman Atua ki te ao Turoa. Providers are resources appropriately so as to provide a nice environment.	Regional networks (District Health Boards) and advisory groups are consistent and congruent in their approach to healthy lifestyles, eg, contracts include reference to a healthy lifestyle plan as a critical dimension.
National	Māori solutions to issues defined by Māori.	Policies workforce plan, eg: <ul style="list-style-type: none"> • HPOs development • Policies that support change process, eg: <ul style="list-style-type: none"> – Kia Tu Kia – Puawai 	Policies that support access to te ao Māori eg: <ul style="list-style-type: none"> • Māori broadcasting • Kohanga Reo Trust • MWWL. 	Policies (macro) eg: <ul style="list-style-type: none"> • employment • education • housing • consultation processes that support participation by Māori. 	Proactive policies to support development of healthy environments and policies. Access and ownership. Treaty settlements.	Proactive policy development that support communities to attain and maintain good health eg: <ul style="list-style-type: none"> • smokefree legislation • cannabis decriminalisation.

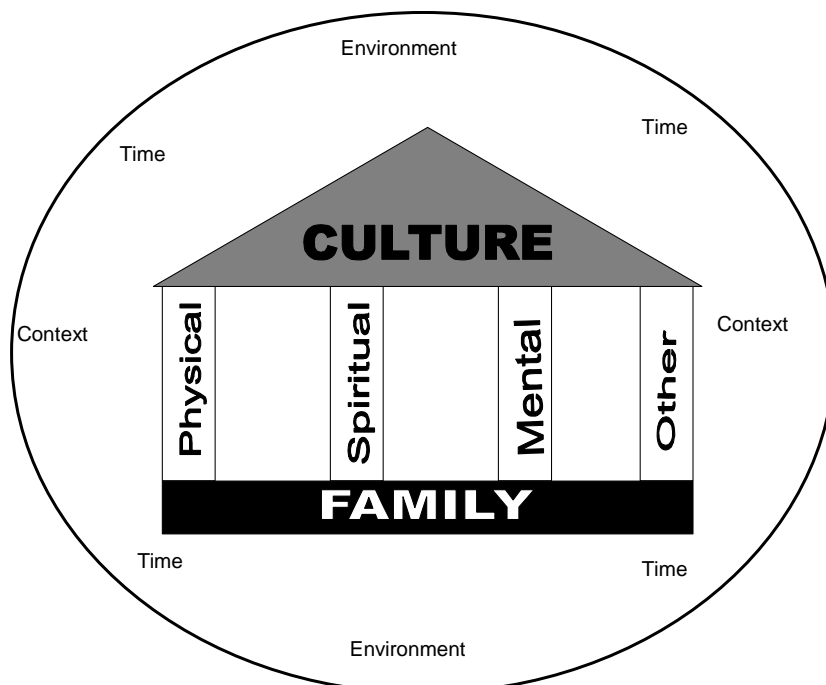
Appendix Three: Pacific Models

Fonofale Model (Samoan model)¹⁰

There are four pillars of wellbeing supporting Pacific culture which is depicted as the roof (see Figure 6). This is set in the wider context of environment and time.

- *The Roof* – represents the Pacific peoples’ culture – shelter for life.
- *Culture* – is the philosophical drive and attitudes. It can also include systems of belief that might be limited to traditional methods of healing on the use of Western trained health professionals.
- *The Foundation* – is the nucleus and extended family/whānau which forms the basis for social organisations for Pacific peoples. The family/whānau provides the base that supports the four posts of spiritual/physical/psychological/other.
- *Spiritual* – the sense of wellbeing which stems from a belief system which can include Christianity, traditional spirituality or a combination of both
- *Physical* – the biological wellbeing of the body which can be measured by the absence of illness and pain.
- *Psychological/mental* – the non-physical aspects of the health of the mind.
- *Others* – this includes things such as gender, employment, sexuality, age, etc.

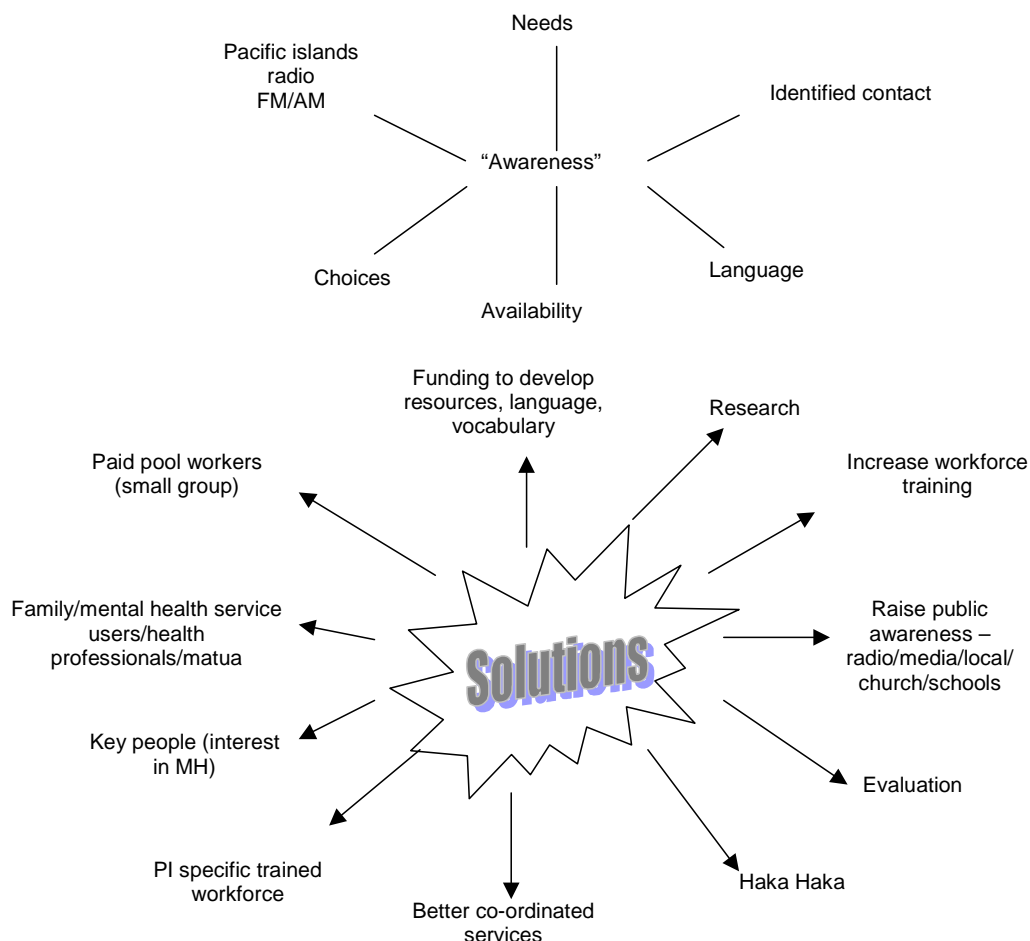
Figure 6



¹⁰ The Fonofale model was developed by Karl Puloto-Endemann.

From a fono held with representatives from Pacific Islands groups the following solutions were put forward in relation to priority mental health and wellbeing issues for each group:

Figure 7



plus: education (family/whānau, client, church, community)/culturally appropriate resources/communities solve problems/elders and influential community members/working co-operatively/ethnic specific services/mental health service user representation/self-determination/cohesive service provision/collaboration from planning to implementation.

Research work being undertaken by the Family Centre in Wellington on Samoan perspectives on mental health has highlighted how this community views wellness as a relational concept and building upon knowledge from collective experiences. There is a weaving together of knowledge from the relational houses (fa’afaletui). Wellness relies upon relational harmony, a balance of the physical, spiritual and mental. A holistic concept is paramount with the individual having meaning in relation to others. Samoan people understand themselves as part of a whole and you cannot therefore remove the Samoan as self from the context they are in.