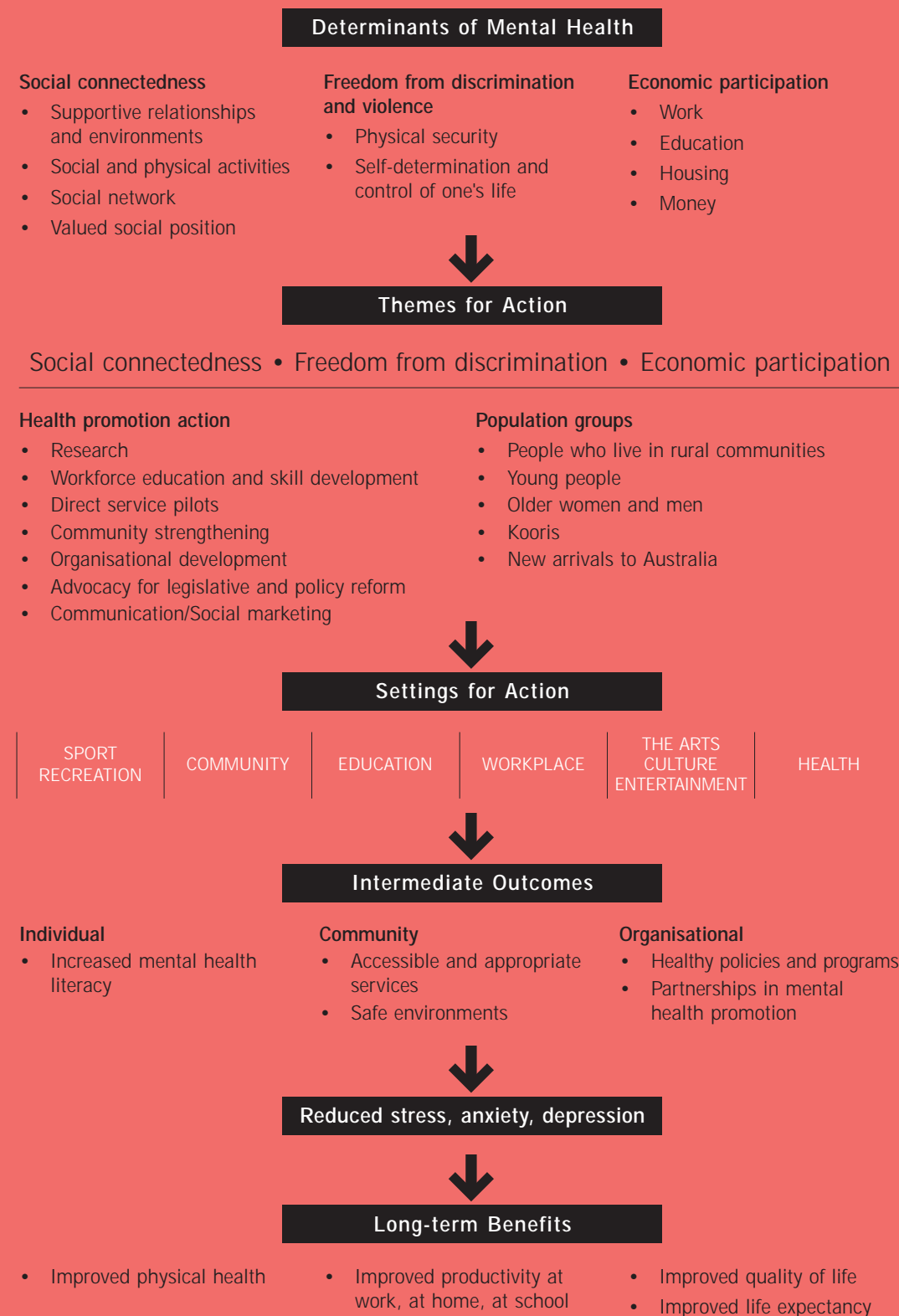


Mental Health Promotion Framework



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Preface

In acknowledgement of the growing social and economic costs associated with the escalating incidence of mental ill health, in 1998 the Victorian Health Promotion Foundation identified mental health promotion as a key area for action over an ensuing three year period.

This Foundation document represents the work of over 100 organisations which joined in partnership with VicHealth to develop a mental health promotion framework and identify subsequent areas for action.

This Foundation document formed the basis of the VicHealth Mental Health Promotion Plan. It represents the work of intersectoral organisations from across Victoria and in particular, the writers who undertook literature reviews, mapping exercises and the development of draft material for comment by specifically convened taskgroups.

The resulting Mental Health Promotion Plan will be implemented throughout 1999 to 2002 and is likely to make a significant contribution to mental health promotion at a national and international level.

Further copies of the Foundation Document and the Mental Health Promotion Plan are available through the VicHealth website <http://www.vichealth.vic.gov.au>

Introduction

There is acknowledgement in Australia and internationally that mental health is fundamental to physical health and quality of life. As early as 1947, the World Health Organization (WHO) defined health as 'a state of complete physical, mental and social wellbeing' (WHO 1947). More recently, the Department of Health in the United Kingdom emphasised the importance of emotional wellbeing for health when it defined health as 'being confident, and able to cope with the ups and downs of life' (Stewart-Brown 1998).

National and international attention is currently focused on increasing the investment in the promotion of mental health and prevention of mental illness. In Australia there are clear concerns which are influencing action to promote mental health as we move into the next century. Of note is the growing incidence of depression and the significant social and economic costs associated with mental health problems. These concerns have underpinned the development of Australia's Mental Health Promotion and Prevention National Action Plan 1999 (the National Action Plan), which focuses specifically on the prevention of mental illness and the promotion of mental health.

According to the National Action Plan: It is becoming increasingly clear that a significant reduction in the [social and economic] costs associated with mental illness will not be achieved purely by activities at the treatment end of the intervention spectrum, but will require interventions that impact earlier in the developmental trajectory of mental health problems. Thus, the call for prioritising mental health promotion, prevention and early intervention in global, national and regional policy making has become critical (Commonwealth Department of Health and Aged Care 1999).

The National Action Plan challenges 'everyone, within and across all sectors to work together to provide quality services, programs and initiatives that involve a spectrum of interventions to reduce mental health disorders and problems and to improve wellbeing'.

On a state level, support for the development and implementation of a Victorian, intersectoral mental health promotion plan is VicHealth's contribution to the challenge ahead.

The 1999 National Mental Health Promotion and Prevention Action Plan challenges 'everyone, within and across all sectors to provide quality services, programs and initiatives that involve a spectrum of interventions to reduce mental health disorders and problems and to improve wellbeing'.

The development and implementation of an intersectoral Mental Health Promotion Plan for Victoria is VicHealth's contribution to this challenge.

The Development Process

It is acknowledged that the promotion of mental health will result in decreased mental illness, better physical health and greater productivity in the workplace, schools, domestic and community environments. The process undertaken to address these issues has involved the development of this Foundation Document and the Mental Health Promotion Plan. This process has involved:

- identifying and documenting the factors that impact on mental health;
- identifying priority population groups for specific attention during 1999-2002 using the criteria set out in VicHealth's strategic plan, Strategic Directions 1999-2002;
- bringing together a wide range of people and organisations to share their expertise and knowledge to inform the process and help develop the strategy and plan (see Appendix 1);
- analysing current policy initiatives to ensure consistency, avoid duplication and add value to current work;
- developing a framework for mental health promotion activity.

Mental Health: A Definition

Definitions pertaining to mental health and social wellbeing are more complex than those associated with the concept of physical health. Many people are more comfortable with terms such as psychological and emotional wellbeing as they equate the term 'mental health' with 'mental illness' (Stewart-Brown 1998, VicHealth 1998).

Much of the mental health literature indicates that mental health relates to emotions, thoughts, relationships and behaviours, with the term mental health often being used interchangeably with emotional, social and spiritual wellbeing (Lehtinen, Riikonen & Lahtinen 1997). The Australian Public Health Association also makes a link between the individual and the community, identifying mental health as associated with a broad range of social and structural factors which impact upon gender roles, the quality of human relationships, family life, work and educational opportunities.

The definition of mental health which is often used to direct policy is:

The capacity of individuals, groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development, and use of mental abilities and achievement of individual and collective goals consistent with justice (AHMC 1992).

The Ministry of Social Affairs and Health in Finland defines mental health not merely in terms of absence of mental disease or symptoms, but also as a resource supporting wellbeing and social integration and an essential element of meaningful life (Lehtinen et al. 1997).

Many of these definitions have been difficult to operationalise. Consequently, we have used the following definition to guide the development of mental health promotion initiatives.

Mental health:

is the embodiment of social, emotional and spiritual wellbeing. It provides individuals with the vitality necessary for active living, to achieve goals, and to interact with one another in ways that are respectful and just.

Mental Health Promotion: Our Aims

The Commonwealth Department of Health and Aged Care indicates that mental health promotion aims to achieve mental health and quality of life across populations by:

- focusing on improving the social, physical and economic environments that determine the mental health of populations and individuals;
- focusing on enhancing protective factors such as coping capacity, resilience and connectedness of individuals and communities in order to improve emotional and social wellbeing;
- identifying the whole population as the target group, although different interventions may focus on specific population sub-groups;
- measuring outcomes in terms of public policy, organisational practices, and organisation of social factors and health literacy.

Through the development and implementation of a mental health promotion plan, VicHealth aims to:

- increase community understanding of the importance of obtaining and maintaining mental health;
- identify and support research and interventions which have the potential to contribute to the mental health of priority population groups and to increase understanding of models of best practice in mental health promotion;
- increase understanding of the mental health benefits of diverse, inclusive and tolerant communities;
- increase capacity of organisations and practitioners to develop, implement and sustain mental health promotion activity;
- further develop a partnership approach to advocate for and foster strong mental health promotion activity across Victoria.

VicHealth has adopted the World Health Organization's approach to health promotion, which indicates that health promotion is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health. These determinants include not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment.

The Conceptual Framework

INVESTING IN PROMOTION AND PREVENTION

VicHealth's mission is to build the capabilities of organisations, communities and individuals in ways that:

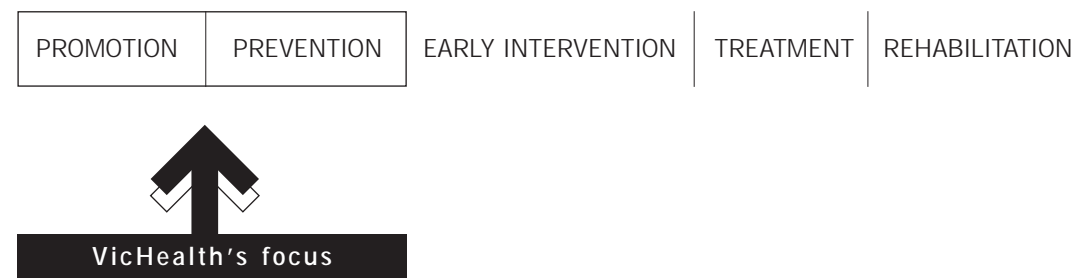
- change social, economic and physical environments so they improve health for all Victorians;
- strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain health.

Investments in health promotion are aimed at achieving a change in structural arrangements such as regulatory activities or policy changes at organisational levels that will support changes at an individual level. At the individual level health promotion action focuses on improving health knowledge and knowledge of appropriate support and services.

Any significant reduction of the social and economic costs of mental ill health can only be achieved by complementing treatment and rehabilitation with mental health promotion and illness prevention approaches. In the past there has been little direct investment by government in the promotion of mental health. There is now enough evidence to support a greater role for health promotion in reducing these social and economic costs of mental ill health. VicHealth has a strong record of support for innovative research and development in prevention of relapse and early intervention for people suffering from mental ill health and substantial activity in sectors outside health that support mental health promotion.

This Foundation Document provides a comprehensive framework for VicHealth's new investments in mental health promotion. It focuses on the broader community and provides a link to activities which address the needs and concerns of people with mental illness.

The following diagram illustrates VicHealth's focus:



THE BENEFITS OF MENTAL HEALTH

The benefits of the promotion of mental health are many, including improvements in physical health and productivity, as well as reduced mental ill health and its associated social and economic costs.

Improved physical health

There is increasing evidence that mental health is important for good quality of life, the maintenance of physical health, and successful treatment and recovery from physical illness (AHMAC Working Group 1997). Similarly, the emerging body of epidemiological, social science and experimental research also suggests that initiatives which aim to promote physical wellbeing to the exclusion of mental and social wellbeing are potentially doomed to failure (Stewart-Brown 1998).

Physical health and mental health are interrelated, and each can impact upon the other. Acute, chronic or life threatening illnesses such as cancer, HIV/AIDS and chronic back pain can have a direct impact on the mental health of individuals (Department of Health and Family Services 1997). Likewise, recent research studies are lending credence to the widespread public belief that many physical diseases may be consequences of emotional distress (Stewart-Brown 1998).

There is strong evidence that social, economic and psychological circumstances can cause long-term stress (Wilkinson & Marmot 1998). In turn, stress may:

- impact on asthma (Scanlon, Williams & Raphael 1997);
- increase susceptibility to viral infection (Cohen, Tyrrell & Smith 1991);
- affect the immune response (Brunner 1997; Wilkinson 1996);
- create susceptibility to diabetes (Wilkinson & Marmot 1998);
- create a susceptibility to a harmful pattern of cholesterol and fats in the blood and high blood pressure, with the attendant risks of heart attack and stroke (Wilkinson & Marmot 1998).

There is also evidence that poor self-esteem can impact on eating habits and on nutrition, dental health and hygiene (Department of Health and Family Services 1997).

Further evidence suggests that the presence of social networks is crucial in the maintenance of mental health. An absence of social ties has also been linked to adverse physical health outcomes (Kaplan and Lynch 1997). The absence of social support has been shown to be related to an increase in coronary heart disease, complications in pregnancy and delivery, suicide, and negative effects in several other diseases. It is also associated with an increased rate of all-cause mortality (Syme 1996).

While some argue that smoking, drinking, illicit drug use and consumption of unhealthy foods are all valued for their ability to relieve emotional distress, these approaches represent a destructive approach to mental health. Conversely, mental health promotion can be as effective in the prevention of unhealthy behaviours and consequent illness as it is in the prevention of mental ill health (Orley 1998).

Further research and field based activity is required to gain increased understanding of the links between mental health and physical health and appropriate interventions which can prevent emotional distress and promote mental and social health (Stewart-Brown 1998).

Improved productivity at work, school and home

There is strong evidence to suggest that there is a relationship between mental health and productivity. If we define productivity in the broadest of terms to include the diversity of activity in which individuals and communities engage, mental health emerges as an important factor. The following data supports the need to invest in mental health as a way to maintain and increase productivity in all realms:

- In the United Kingdom, mental health disorders were found to account for one third of days lost from work due to ill health and one fifth of consultations in general practice (Williams, Tarnopolosky, Hand & Shepard 1986; Jenkins 1985).
- Approximately 5% of Australians experience anxiety so crippling that it affects every aspect of their lives. Often it makes it difficult for them to hold down jobs, form and maintain relationships, or enjoy normal leisure activities (Australian Bureau of Statistics 1997).
- Students experiencing anxiety are less likely to excel academically than those reporting high levels of wellbeing (Samdal, Nutbeam, Wold & Kannas 1998).

Lehtinen, Riikonen & Lahtinen (1997) argue that mental health disorders affect functional and working capacity in many ways. When the disorder begins during childhood or adolescence, it means that the person's working capacity may be reduced or totally lost for a long period, perhaps during the total productive life span.

Reduced mental ill health and its associated social and economic costs

According to the World Bank and WHO, mental health disorders constitute 10% of the global burden of disease, with estimates suggesting that depression alone will constitute one of the largest health problems worldwide by the year 2020 (Murray & Lopez 1996).

When analysing existing data according to lifespan and population groups, some significant trends emerge:

- It is estimated that approximately one in five children and adolescents in Australia are affected by mental health problems, with at least half showing impairment in schooling and social development (Commonwealth Department of Health and Aged Care 1997b; Zubrick, Silburn, Burton, Dalby, Carlton, Shepherd & Lawrence 1995). Recent government enquiries also indicate a high prevalence of mental health problems among young people and that the incidence of youth suicide and depression is rising (McLennan 1998; Victorian Suicide Taskforce 1997).
- Eighteen per cent of adults are affected by mental health disorders (McLennan 1998).
- There is a high incidence of mental health disorders affecting older women (ABS 1997).
- Indigenous Australians have clearly documented mental health concerns requiring response. Specifically, much of the research and literature developed over the past decade highlights the importance of addressing mental health as a vital element of Indigenous Australians progressing towards an improvement in their overall health status (Human Rights & Equal Opportunity Commission 1998; AHMAC Working Group 1997).
- An emerging body of literature refers to the poor mental health status of those who are new arrivals to Australia. Research indicates that those from refugee-like situations experience high rates of mental illness, in particular post traumatic stress disorder, anxiety and depressive disorders, that well exceed the rates in the general population (Silove 1994; Simpson 1993).

- There is clear evidence indicating that social, economic and environmental conditions have significant impact on mental health, with people from low socioeconomic backgrounds experiencing poorer health and wellbeing than those in other groups (Wilkinson & Marmot 1998; Kaplan and Lynch 1997; Secker 1997; Silva 1998; Syme 1996). This is supported by data from the ABS 1997 which showed that both men and women who were unemployed reported poorer mental health than those employed full-time. The ABS also found that Australians who lived in households with an income in the lowest 30% reported poorer mental health than those who lived in households with an income in the highest 30%.

There are escalating social and economic costs associated with decline in mental health status. The Australian Institute of Health and Welfare (AIHW) reports the direct economic cost of mental health disorders and problems in Australia was estimated to be \$2 billion in 1989-90 (1996). The AIHW also indicated that:

Such estimates do not include community costs, family impact, and the need for welfare response and coronial work in the case of suicides (1996).

Further, in relation to suicide and suicide attempts, the health costs and loss of earnings over a one year period were estimated to be \$920 million for the financial year 1989-90 (Commonwealth Department of Health and Aged Care 1999).

Benefits of mental health:

- improved physical health
 - improved productivity
 - reduced mental ill health and its associated
 - social and economic costs.
-

Influences on mental health

Relevant literature indicates that mental health is a combination of a range of determinants that operate at several levels. This point is clearly articulated by Borthwick (1988) who argues that mental health is affected by social factors such as the larger structures of society (the distribution of wealth, the nature of hierarchies), the circumstances of the immediate setting, and the support available. It is also affected by the individual's heredity, luck, knowledge, attitudes, skills and relationship to the economic and social system both as an individual and as a member of one or more population groups.

Table 1 shows the determinants of mental health and mental ill health that featured consistently in our review of the literature. Some of the key themes identified as significantly influencing the mental health of individuals and communities are social connectedness, individual support resilience and control, discrimination, conflict and violence, and economic participation.

Mental health determinants

<p>Social connectedness, including:</p> <ul style="list-style-type: none"> • social and community connectedness • stable and supported environments • variety of social and physical activities • access to social networks and supportive relationships • valued social position 	<p>Freedom from discrimination and violence, including:</p> <ul style="list-style-type: none"> • physical security • opportunity for self-determination and control of one's life 	<p>Economic participation including:</p> <ul style="list-style-type: none"> • access to work and meaningful engagement • access to education • access to adequate housing • access to money
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Table 1: Summary of mental health determinants identified in the literature

Social connectedness

An individual's level of social integration and social support are powerful predictors not only of their mental health status but also of morbidity and mortality:

... social relationships or lack thereof, constitute a major risk for health - rivalling the effects of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity. The age-adjusted relative risks are stronger than the relative risks for all causes of mortality reported for cigarette smoking (AHMAC Working Group 1997).

The size of an individual's social network, the supportiveness of the network relationships and recent change or disruption to the network are important factors in determining mental health and mental ill health (depression in particular). 'Good social relations' make an important contribution to health. By belonging to a social network, and through communication and mutual obligation, people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health (WHO 1998).

The Gatehouse Project, a research program being undertaken by the Centre for Adolescent Health (Victoria), indicates that social connectedness involves having someone to talk to, someone to trust, someone to depend on and someone who knows you well (Glover, Burns, Butler & Patton 1998). The link between social connectedness and mental health includes the following evidence:

- Young people reporting poor social connectedness are between two and three times more likely to experience depressive symptoms when compared with peers who reported the availability of confiding relationships (Glover et al. 1998).
- Socially isolated people die at two or three times the rate of people with a network of social relationships and sources of emotional support (Brunner 1997).

It is apparent that social capital, including social support, is a critical factor in determining the extent to which all individuals manage life's challenges and the extent to which we become susceptible to the development of mental health problems. Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people that

establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit. Increasing evidence also shows that at a community and societal level, social capital is critical for poverty alleviation and sustainable human and economic development (World Bank 1998). Likewise, various studies have suggested that social capital is as important for the maintenance of health and wellbeing as income differentials.

The emerging body of literature focusing on social capital and citizenship makes clear links between the mental health status of individuals, communities and sub-populations and the extent to which they experience support, acceptance and opportunity for valued contribution (Baum 1999; Putnam 1993, 1995).

Experiences of family conflict and separation, management of a disability, chronic or life threatening illness, or bereavement through loss of significant relationships, lifestyles or loved ones are common features of everyday life which can have a devastating impact on individuals. Stresses associated with full-time childcare responsibilities and lack of access to a variety of activities, including recreation, are also mental health determinants which feature consistently throughout the literature. Life transitions, such as going to school, moving from childhood to adolescence and entering retirement also impact on mental health (Commonwealth Department of Health and Aged Care 1999).

Clearly, the effective management of each of these experiences will be affected by factors such as social support, information, and material and other resources available. However, it is also clear that coping strategies previously developed in life and the individual's sense of self and self-control will determine the extent to which negative life experiences are coped with or precipitate mental health problems. This coping phenomenon features in much of the mental health literature and is referred to as 'individual resilience'.

It is critical to recognise that control and self-control feature throughout the literature as fundamental components of mental health. The extent to which people have a sense of being in control of their lives clearly determines their capacity to achieve and maintain mental health.

Discrimination, conflict and violence

The macro social and economic environment has a direct impact on the formation of relationships within the whole population, between sub-populations and at a community level. Nowhere is this clearer than in instances where discrimination, conflict and violence become inherent components of social relationships and where policies, structures and systems appear to reinforce and perpetuate these phenomena.

In response to this, the Health Education Authority in the United Kingdom (HEA) recently launched a mental health campaign designed to identify and address the level of discrimination impacting on specific sub-populations within their society. The campaign acknowledges the negative mental health impacts stemming from discrimination and the positive attributes of societies which value diversity. The campaign focuses specifically on racial discrimination, homophobia, sexism, ageism and stigma towards those with a mental illness.

In Australia, it is vital to understand and acknowledge a history of colonisation and the profound effects that health, economic and social policies continue to have on the mental health of Indigenous people (AHMAC Working Group 1997). Any strategies which are designed to respond to the ill health caused by racism and conflict therefore need to commence with recognition of the particular experiences of Indigenous Australians.

While the original custodians of the land continue to experience racial discrimination it is apparent that those newly arrived to Australia, many of whom are dealing with the effects of war, torture and trauma, are also affected by discrimination. The impact of arriving in a country after these experiences and being subject to racial intolerance in a range of forms has a significant impact on their mental health. The recent popularity of political parties which had intolerance to diversity as a theoretical and practical underpinning of their policy platforms is an example of the racial intolerance that those people who are newly arrived to Australia may face.

Discrimination targeting women is also a fundamental feature of the social fabric of our society. Professor Beverley Raphael, when addressing the links between the position of women in society and mental health, says:

There is so much evidence that the adverse place of women in society, the lesser place of women in society, contributes in multiple ways to women's lack of mental wellbeing, to problems with their mental health, and often to problems with their physical health (Raphael in Sorger 1995).

A substantial body of evidence spanning some eighty years makes direct links between the position of women in society and the overwhelming level of violence perpetrated against them (Department of Human Services 1998; Gilmore Centre 1997; National Committee on Violence Against Women 1995). Violence against women has in turn, been well documented as a significant determinant in their mental health status (Dean & Hardiman 1998; Commonwealth Department of Health and Aged Care 1999).

There is also a substantial body of literature relating to violence against children which cites experience of childhood abuse, including incest and other forms of sexual assault, as a fundamental determinant of mental ill health (Commonwealth Department of Health and Aged Care 1999; Kaufman and Seitz 1994). A wide range of services, including refuges and Centres Against Sexual Assault, have been designed to respond specifically to the sequel of this violence. However, the role of health promotion with victims/survivors and the role of prevention has yet to be mapped in this domain.

Discrimination in relation to age is also a subject of community concern. Both young people and older people cite different experiences of ageism. For example, there are prolific popular representations of young people which show them as drug addicts or unemployed. Conversely, older people are frequently represented as inactive or infirm, thus making invisible the contribution and activities of older women and men.

Specific examples of the link between discrimination, conflict and violence and mental health include:

- The University of Surrey (1988) found the most common results of discrimination to be lower self-esteem, social isolation, depression and anxiety, drug and alcohol misuse and suicidal feelings.
- In developed countries, 19% of the total disease burden of women aged 15-44 is caused by rape and violence (Doyal 1998).
- Sex discrimination against women in the form of violence and abuse has been found to lead to higher levels of anxiety, depression, stress, alcohol abuse, chronic tranquilliser use and higher utilisation of medical care (Raphael & Martinek 1995).

- The Indigenous youth suicide rate is four times that of the non-Indigenous youth suicide rate (Department of Health & Family Services 1997).
- A large percentage of young people who attempt suicide are gay, lesbian or bisexual (National Children's and Youth Law Centre 1998).
- Young people who are victimised are three times more likely to be at risk of having depressive symptoms when compared to those not reporting such experiences (Glover et al. 1998).

Economic participation

Good health involves reducing levels of educational failure, the amount of job insecurity and the scale of income differences in society. We need to ensure that fewer people fall and that they fall less far. Policies for education, employment and housing affect health standards. Societies that enable all their citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation (Wilkinson & Marmot 1998).

Emphasis on social and economic factors has become an increasingly dominant aspect of health promotion thinking over the last decade, stimulated in part by the work of the WHO which culminated in the Ottawa Charter For Health Promotion 1986 (Duckett 1998; Kickbusch 1996). Consequently, the interrelationship between environmental factors and mental health has legitimacy in the development of health promotion policy and practice.

Theorists such as Kaplan and Lynch (1997) argue that in an era characterised by downsizing, reductions in benefits, globalisation, use of temporary workers and welfare reform there is an urgent need to document and understand the impact of these economic and social policies on the health of populations. Clearly research into the impact of such policies on the health and wellbeing of populations would make a considerable contribution to future policy development and reform.

Demanding, unrewarding and stressful work environments have also been shown to have significant impacts on mental health. The 1998 Australian Council of Trade Unions workplace survey indicated that the five top causes of workplace stress are lack of communication, increased workload, job insecurity, organisational change and poor work organisation. It is clear that these are issues to do with the health of the organisation, not only the individual, and consequently must be addressed at the level of structural change rather than just individual behaviour change (Borthwick & Moodie 1999). It is also clear that workplace health promotion activity can assist to support this structural change.

Specific examples of the link between economic participation and mental health include:

- Unemployed people experience higher levels of depression, anxiety and distress as well as lower self-esteem and confidence (McLelland & Scotton 1998).
- The prevalence of poor health increases with decreased social position as indicated by health problems such as malaise, obesity and self-rated health status (Power, Hertsman, Mathews and Manor 1997).
- People living in areas with greatest inequalities in income are 30% more likely to report their health status as fair or poor than those living in areas with the smallest inequalities in income (Kennedy, Kawachi, Glass and Prothrow-Smith 1998).

- Reducing income inequality offers the prospect of greater social cohesiveness and better population health (Wilkinson 1997).

Clearly, an effective mental health promotion plan needs to acknowledge the full range of factors at the socioeconomic and environmental levels, as well as the individual level.

The Finnish Ministry of Social Affairs and Health (1988) concluded that:

the social and environmental factors of greatest importance are housing and community planning, quality and level of education, employment and working conditions. Improvement of the health level, including the level of mental health and wellbeing, must take account of the unfavourable living conditions of many groups and communities.

A mental health promotion methodology

Traditional health promotion practice has focused on behaviour modification and social marketing strategies, with emphasis on health education to assist individuals to combat unhealthy conditions. Contemporary health promotion acknowledges the importance of health promotion interventions to assist individuals to develop knowledge and skills to cope with their living and working environments. However, it also places emphasis on approaches which move beyond the development of individual skills to a focus on interventions which combat these unhealthy conditions at their source (Duckett 1998; WHO 1997, WHO and Canadian Public Health Association 1986; AHMAC Working Group 1997; Secker 1997; Syme 1997).

Robertson & Minkler (cited in Duckett 1998) suggest that the prominent features of the newer approach to health promotion include:

- broadening the definition of health and its determinants to include the social and economic context in which health – or more precisely, ill health – is produced;
- going beyond the earlier emphasis on individual lifestyle strategies in achieving health, to broader social and political strategies;
- embracing the concept of empowerment – individual and collective – as a key health promotion strategy;
- advocating the participation of the community in identifying health problems and strategies for addressing those problems.

While health promotion theory leads contemporary practitioners to focus on the design of projects and programs which work at an institutional, structural, systems and community level, and in so doing focus on the upstream determinants of health, contemporary literature also indicates that:

... health promotion practice remains limited in this area with attention to inequalities appearing to be little more than lip service paid in introducing the topic of mental health promotion. Rather than addressing social and economic inequalities, many interventions aim to assist oppressed groups to develop skills to cope with the destructive effects of poverty and discrimination (Secker 1997).

As VicHealth moves into a new decade of operation it is timely to strengthen activities which focus on structures, systems, communities and environments to promote health, and to make visible the socioeconomic and cultural determinants of health in order to educate public policy makers away from individualist models (Goldberg in Jenkins and Unstun 1998).

Integral to the development of mental health promotion initiatives has been acknowledgement of:

- human rights and citizenship entitlements as crucial elements of any mental health promotion strategy;
- the social, economic and environmental influences on mental health which are often outside the individual's control;
- the need to initiate strategies designed to bring about change in societal structures affecting health in addition to strategies designed to assist individuals to develop their personal knowledge and skills so that they can cope with their living and working environments;
- the need to incorporate aspects of social justice and community empowerment if we are to undertake good health promotion which leads to ongoing and transferable change;
- the importance of developing collaborative partnerships to create a favourable climate in which mental health promotion can thrive;
- the fact that successful action to promote mental health and prevent mental health problems can only be achieved and sustained with the involvement and support of the whole community, and the development of collaborative partnerships with a range of agencies throughout public, private and non-government sectors (both within the health sector and in other sectors that influence the way in which people live, are educated and work);
- the crucial importance of diverse combinations and mutually reinforcing methods and approaches to mental health promotion. This includes approaches such as research and evaluation, advocacy, legislative and policy reform, organisational change, community development, workforce development, direct service piloting and media communication.

Proposed Areas for Investment

Priority themes

While the factors affecting mental health are complex and varied, three central themes were identified from the review of the literature and the consultation process as informing the focus of our Plan and subsequent activities. These themes are:

- social connectedness
- valuing diversity and working against discrimination
- economic participation.

Social connectedness to promote mental health

Social connectedness involves having someone to talk to, someone to trust, someone to depend on and someone who knows you well (Glover et al. 1998).

Valuing diversity and working against discrimination to promote mental health

Victoria is a diverse community. However some individuals and communities experience less favourable treatment than others.

Economic participation to promote mental health

Economic participation is not simply a question of full employment, but access to the money necessary to feed, clothe and participate in community life.

A targeted population approach

Opportunities for promotion and prevention in the mental health field exist across a range of target audiences. With finite resources it is advantageous to focus our mental health promotion efforts.

VicHealth's strategic plan, Strategic Directions 1999-2002, identifies the following criteria for choosing priority populations and priority health promotion action areas for its programs:

- **consonance with basic values**
Programs must accord with equity, autonomy and human rights.
- **scale of health issue**
Programs must target interventions to areas where there is the greatest burden of disease and disability and scope for significant health gains.
- **feasibility of intervention**
Programs must have reason to believe that interventions in these areas have a significant prospect of actually achieving the hypothetical health gains.
- **comparative advantage**
Programs must be in areas where it is possible to add value to other state, federal and non-government agency initiatives.

Utilising these criteria, VicHealth has chosen promotion of mental health in the following populations for specific attention during 1999 – 2002:

- rural communities
- young people
- older women and men

- Koori communities and
- people newly arrived to Australia (particularly those coming from areas of conflict).

Independent yet related mental health promotion initiatives have been developed for each of these groups through a process of consultation with appropriate stakeholders and other people and organisations with knowledge and expertise in the area. These initiatives are outlined later in this document.

In the development of these initiatives, VicHealth was cognisant of the importance of maintaining consistency with current policy, avoiding duplication of activities and adding value to current work. Consequently, state and national mental health policy and policy relevant to our priority population groups was analysed. A literature review was undertaken to gain insight into the factors affecting mental health in each group, and current models of best practice in mental health promotion and relevant current activities were mapped. The taskgroups convened to provide advice in the development of the Plan also considered what guiding principles should be followed in planning activities to promote mental health in each particular population group.

Our Mental Health Promotion Plan targets:

- **Rural communities**
- **Young people**
- **Older women and men**
- **Koori communities**
- **New arrivals to Australia.**

A range of activity approaches

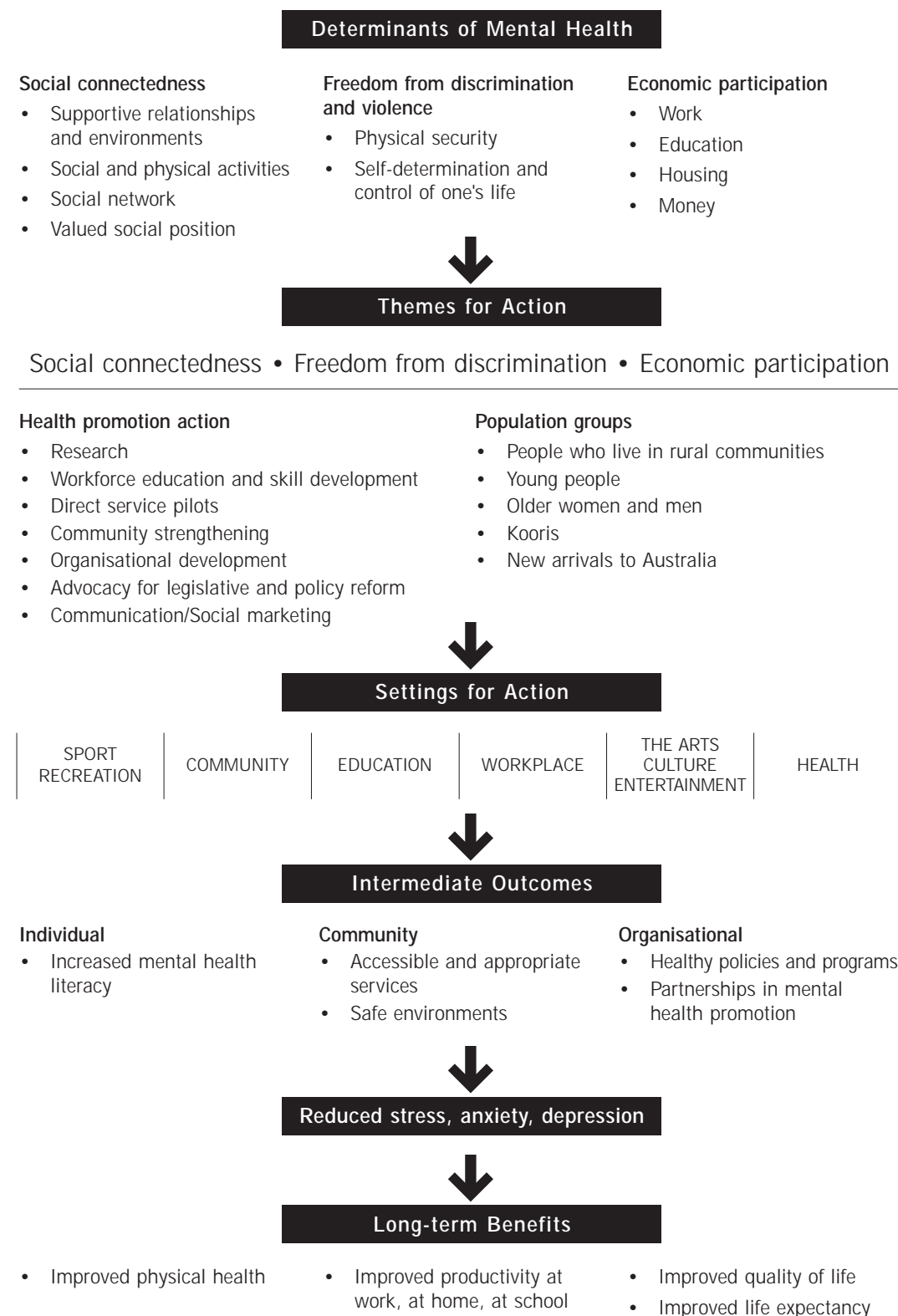
Activities focused on these population groups will work at an organisational level (eg in schools and in the workplace) and at the individual level (eg building skills and resilience) to increase social connectedness, decrease discrimination and increase economic participation. A range of approaches will be adopted incorporating:

- research, including implementation research and evaluation to improve the evidence base for mental health promotion;
- organisational development to ensure ongoing support and services for mental health promotion;
- processes that enable communities to mobilise and address community health issues that impact on mental health;
- education and training with relevant workforces and professionals;
- piloting new direct services to determine efficacy and effectiveness;
- comprehensive communication strategies;
- advocacy for legislative and policy reform when evidence is available;

A range of approaches:

- **Comprehensive communication strategies**
- **Piloting new direct services**
- **Education and training**
- **Advocacy**
- **Organisational development**
- **Empowering communities**
- **Research**

Mental Health Promotion Framework



Putting the Plan into Action

Implementation

VicHealth will provide support for implementation of activities identified in this document through:

- purchasing and/or commissioning programs and projects that may involve the strengthening and extending of existing programs and projects (such as the Program of Resources, Information and Support for Mothers). This will include the development of new large scale programs spanning three years (such as a statewide local government community arts program), medium size projects spanning two years (such as an initiative designed to support young rural people to deal with sexuality issues), and short-term small projects (such as activities under the Active for Life small grants program).
- brokerage to ensure innovative and collaborative funding models are created and that the business sector, and local, state and national governments, have opportunities to invest in relevant activities.
- advocacy and communication to ensure that mental health promotion initiatives are undertaken at a community and organisational level and by government at its three tiers.

Consequently, responsibility for implementation of activities identified in this Plan will reflect the collaborative spirit in which the Plan has been developed. It will also reflect a recognition that the promotion of mental health is intersectoral in nature and is therefore the responsibility of communities, organisations, businesses and governments.

All areas of activity will be developed through commission, tender or funding rounds, with project proposals being assessed by expert committees and boards.

Evaluation

VicHealth plays a leading role in the support and development of research and implementation trials designed to generate knowledge in health promotion. One of the main difficulties in the evaluation of mental health promotion is setting indicators for mental health instead of using mental illness indicators.

In the absence of any national or state system for evaluating mental health promotion projects, VicHealth in conjunction with La Trobe University's VicHealth Evaluation Program will develop a formal evaluation strategy and appropriate indicator set for the Plan and its individual components.

The evaluation strategy will include the development of commonly agreed outcomes as measures of what constitutes effectiveness, as well as costs, quality and efficiency of initiatives. In addition, a review near the end of the three years will examine the outcomes of the initiatives developed to assess the extent to which our objectives are met and what continued work is required to maintain the process of mental health promotion.

Dissemination

VicHealth is committed to sharing the knowledge gained from its projects. To assist with this:

- funded organisations will be required to disseminate the outcomes of project activity;
- dissemination strategies for each area of activity will be developed according to the focus of the project and the constituency involved;
- dissemination strategies will be submitted with project proposals and will form the basis of assessment for resource allocation.

The Targeted Initiatives

Anticipated outcomes

By 2002, VicHealth will have contributed to:

- increased community understanding of the importance of obtaining and maintaining mental health (measured through evaluation of the communication strategies developed);
- illustrating the mental health benefits of social connection, inclusion and economic participation (achieved through research projects and evaluation of funded projects and programs);
- identification of models of best practice in mental health promotion (measured through evaluation of funded projects and programs);
- development of organisations and practitioners to implement and sustain mental health promotion activity (facilitated and evaluated through workforce development and organisational projects);
- development of sustained mental health promotion projects and programs (facilitated and evaluated through workforce and organisational development projects and measured by the number of projects sustained beyond the funding period);
- consolidation of partnerships to advocate for and foster strong mental health activity across the state (measured through planning input, joint funding and shared ventures).

Mental Health Promotion:

- Valuing diversity and working against discrimination
- Enhancing social connectedness
- Improving economic participation

RURAL COMMUNITIES

YOUNG PEOPLE

OLDER WOMEN AND MEN

KOORI COMMUNITIES

NEW ARRIVALS TO AUSTRALIA

RATIONALE

ISSUES AFFECTING MENTAL HEALTH

FACTORS PROMOTING MENTAL HEALTH

ISSUES TO GUIDE ACTIVITY DEVELOPMENT

PLANNED MENTAL HEALTH PROMOTION ACTIVITY 1999-2002

RURAL COMMUNITIES

Rural Communities – A Rationale for Mental Health Promotion

There is considerable evidence indicating that people who live in rural and remote locations have particular needs in relation to mental health. For example:

- Aboriginal people in rural and remote localities suffer from higher levels of general ill health by urban standards (HREOC 1999).
- There are increasing numbers of young rural people seeking help from public mental health services (Department of Human Services Draft Rural Health Strategy 1999).
- Data collected by the Victorian Suicide Prevention Taskforce showed that there were high rates of suicide among young people in country Victoria. Young women and men living in small, isolated country towns are most vulnerable to high suicide rates. The suicide research indicates that this vulnerability is particularly evident for young men, although young women attempt suicide at dramatically higher rates (Victorian Suicide Task Force 1997).
- Young gays and lesbians have been found to experience particular discrimination in relation to sexuality which has direct impact on their health status (Hillier, Dempsey, Harrison, Beale, Matthews and Rosenthal 1998; Victorian Suicide Task Force 1997).
- A significant range of rural women's mental health issues have been identified as requiring attention, including isolation, post natal depression, sexuality and sex role stereotyping (National Rural Health Alliance 1997).

Rural communities are not homogeneous, with different localities having different needs arising from factors such as loss of local industry and diminished access to information systems such as telephones or other technology. Isolation, changing structure and infrastructure in many rural communities, high unemployment and exposure to environmental hazards such as drought, flood and fire each contribute to the mental health or ill health experienced by people in rural Victoria.

The mental health status of rural Victorians is exacerbated by poverty and unemployment, which are relatively higher than in urban areas (Matthers 1994). The three indicators of socioeconomic wellbeing calculated from the 1991 Census were economic resources, education/occupation and disadvantage, all of which have been shown to be negatively impacted upon with increasing distance from a major urban centre (Australian Institute Health and Welfare 1998).

Issues Affecting the Mental Health of Rural Communities

The paucity of information about the range of issues affecting the mental health of Victorians in rural and remote locations is itself a serious concern and has a direct impact on resource allocation to address these issues. According to one researcher, the invisibility of the dramatic disadvantage of rural Australians is due to a lack of research into issues affecting them (HREOC 1999).

Issues that have been identified as impacting on mental health in rural communities include:

- structural change;
- access to services;
- changes in social capital;
- gender stereotyping;
- environmental disasters.

Many of these issues are interrelated.

STRUCTURAL CHANGE

Research has shown that the outcome of long-term structural change for rural communities is a population which is poorer, sicker and more unemployed, with higher suicide rates and higher domestic violence rates than people in urban centres (Sheil 1997). Some of the pressing issues facing rural and regional Australia which affect quality of life and the mental health of rural communities include closure of services, economic viability of small communities, agricultural change, industrial restructuring and social polarisation (HREOC 1998). Indeed, a significant issue for rural people generally has been found to be changes introduced by policy makers, by labour market deregulation and by international markets all of which contribute to rural people feeling that the circumstances that affect their communities are out of their control.

Some examples of these changes identified in taskgroup discussion include:

- reforms encouraging amalgamation, privatisation, closures and job losses;
- high fuel costs and decreased demand and prices paid for some primary products;
- amalgamations of shires and cutbacks to local services which are perceived to have impacted severely on social cohesiveness;
- hospital restructuring. Hospital closures have been traumatic, with no attention paid to the grieving process which followed the loss of the sense of safety and economic strength which the physical hospital provided (Wainer 1997);
- introduction and use of technology, which is replacing traditional face-to-face consultation;
- new issues for some regions, such as the introduction of gaming facilities (especially poker machines).

ACCESS TO SERVICES

Barriers in accessing health services are present in many rural and remote communities, and include distances between towns and services and the shortage of specialised services. Some of these barriers, identified through taskgroup discussion, are also related to structural change. For example:

- Restructuring of maternal health services has limited access to support for young mothers. This has coincided with early discharge from hospital which has increased their need for home-based support.

Factors Promoting Mental Health in Rural Communities

- Visiting nursing services now charge for their service. It is estimated that post natal depression affects more than 20% of Australian mothers. Post natal depression often goes undiagnosed and unmanaged in rural areas.
- There are limited options available to seek employment or exercise consumer choices in relation to social, human and health services.
- Increases in fuel prices and decreases in road maintenance have been perceived to compound people's isolation and limit their ability to participate in community life.

SOCIAL CAPITAL

Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people that establish networks, norms and social trust, and facilitate coordination and cooperation for mutual benefit. Social capital has a history of being central to the maintenance of mental health in rural communities and has been significantly impacted upon by some of the recent changes experienced.

Competitive tendering in rural areas, for example, has led to competition between people who have a history of cooperation and making urban-based structures work in their town. The impact of this service contracting approach has had the effect of diminishing cooperation between individuals and agencies with regard to sharing of information. This in turn impacts on overall cooperation, which is crucial to the maintenance of cohesive communities essential to mental health promotion strategies. In turn, volunteerism is now more complex because volunteers are being sought to provide services which were formerly the province of governments.

The unhealthy side of social capital which is also apparent in rural communities is distrust of strangers, a 'them and us' attitude which excludes people who are outside the networks, fear of the unknown, racism and dislike of change (Baum 1999).

GENDER STEREOTYPING

A narrow construction of masculinity and femininity in many rural communities is perceived to lead to health-damaging behaviours for males which in turn impacts on the rest of the community. According to Allen, a culture of violence raises significant concerns about personal safety (eg incidence of domestic assault, gun-related injury and homicide). In addition, a culture of violence contributes to social isolation within the community, neuroticism, depression, and a range of health issues which affect families and the aged for whom there is no close community network for support (Allen 1997).

ENVIRONMENTAL DISASTERS

Environmental disasters such as flood, drought and fire can have considerable impact on rural communities. Walker (1996) found, for example, that drought can affect the mental health of rural communities leading to anxiety, depression, family and communication breakdown, grief and anger.

Healthy rural communities will have substantial social capital. Additional determinants which contribute to resilience and mental health in a rural context are:

- access to income and meaningful work;
- a sense of belonging and being worthy;
- connection with community and the environment;
- an emotional support network of family and community;
- the possibility of self-determination in work, for example being able to set your own hours and tasks in occupations such as farming;
- a feeling of safety in the home and the environment (freedom from fear in the community);
- access to essential services;
- a sense of control over decision making.

Issues to Consider when Developing Mental Health Promotion Activity

The National Rural Health Alliance (1997) identified a range of criteria to assist the survival of rural communities. The Rural Communities Taskgroup considers that planned mental health promotion activity in rural communities should take these criteria into account and therefore involve:

- collaborative work between funding bodies and rural communities;
- communication in a language that the community understands;
- goals developed with genuine consultation with the community;
- programs designed in rural rather than urban environments;
- programs based on fostering the capacity of the community to promote their own mental health;
- supporting rural communities to enhance their sense of control. This will help create supportive environments and strengthen community capacity to address the social and structural factors which impact on their health;
- reducing inequities in income, unemployment and access to essential services.

Issues affecting the mental health of rural communities:

- Structural change
- Access to services
- Social capital
- Gender stereotyping
- Environmental disasters

PLANNED MENTAL HEALTH PROMOTION ACTIVITY 1999-2002

Rural Communities

Research

VicHealth, in partnership with relevant organisations, will advocate for and support the development of research which:

- identifies mental health determinants relevant to rural communities;
- identifies the social and mental health benefits associated with use of rural sporting facilities.

Implementation Trials

VicHealth, in partnership with relevant organisations, departments and funding bodies will:

- provide ongoing support to the rural components of Program of Resources, Information and Support for Mothers (PRISM). This program aims to reduce the prevalence of depression and physical health problems in mothers up to two years after giving birth, by conducting and evaluating an integrated program of community based and primary care strategies;
- foster activity designed to enhance the enterprise, leadership skills and opportunities of young rural people;
- support community development projects which build on and strengthen rural networks and activities to promote social connection, inclusion and economic participation;
- develop and implement activity which increases supports available to young rural people regarding sexuality issues, particularly young gay and lesbian people who are experiencing discrimination;
- support documentation of good practice in community based transport which increases access to community facilities and provide seeding funding to implement good practice models in other rural areas;
- improve access to physical activity and recreation for rural people, particularly rural women, through continuing support for a range of existing programs;
- support statewide local government activity which increases access for rural people to community arts and recreation projects which facilitate skill development, enhance social connectedness and highlight the positive aspects of diverse communities.

YOUNG PEOPLE

Young People – A Rationale for Mental Health Promotion

Young people are not a homogenous group, with their diversity reflected in terms of gender, class, cultural background, socioeconomic status and, indeed, age. For the purposes of this Plan, we have targeted issues affecting young people between the ages of 12-17 years. Young Koori people, young people from culturally and linguistically diverse backgrounds and young rural people have been identified by the Department of Education as requiring special consideration and have also been a specific focus in this strategy (Department of Education 1998).

Young Australians have been a central focus for the Federal Government and State Government due to significant community concern with mental health problems and the increased number and rates of young people who have committed suicide over the past thirty years (Victorian Suicide Task Force 1997). Mental health and wellbeing in adolescence can have a significant impact on future relationships, education, future employment and individual functioning. The Health Education Authority suggests that 'young people are particularly vulnerable to stressful events because at this time in their lives they are already coping with many changes, both physical and emotional' (1998). The Health Education Authority also suggests that young people are particularly in need of support because unsolved problems may carry through to adulthood and develop into more serious problems in later life (HEA 1998).

Issues Affecting the Mental Health of Young People

Data on the mental health of young people is affected by particular methodological issues and the difficulties associated with seeking young people's perceptions of their own health and wellbeing. Much of the recorded data is collected at the acute end of the mental ill health spectrum. While a significant proportion of young people are affected by mental health problems, the vast majority experience a sense of wellbeing. As indicated by Wyn (1998), with the significant focus on the ill health of young people, it is important to recognise that young Australians have also been found to be productive and well adjusted members of our society.

It has been estimated, however, that up to two-fifths of young people in the community suffer from depressed mood in any six month period (NHMRC 1997). Studies estimate that between 10% and 15% of adolescents will experience a major depression by the time they reach the age of 18 years. The mean age for onset is approximately 15 years. Young women experience earlier onset than young men. Indeed, young women are considered to experience much higher rates of depression than young men (NHMRC 1997).

There are a number of indicators which have been confirmed as risk factors for adolescent depression. These include:

- conditions or symptoms such as anxiety, conduct disorder or substance abuse;
- being an older (15 to 17 years) as opposed to a younger adolescent (13 years);
- being female;
- having a depressed parent (NHMRC 1997).

The National Stocktake of Early Intervention Programs (1998) also identifies factors that place a young person's mental health at risk. These include:

- family violence, physical or sexual abuse;
- school failure;
- parenting difficulties;
- stressful life events;
- homelessness;
- unemployment;
- parental mental illness;
- being a member of an 'at risk' group of young people (eg rural and isolated, socially disadvantaged, unemployed early school-leavers);
- lack of control and a sense of hopelessness about opportunities for the future.

Suicide among young people is one of the most critical consequences of depression. Australia has a reasonably high suicide rate among developed countries, particularly among young males. Twenty per cent of all adolescent deaths are the result of suicide (25% of deaths in young men; 17% of deaths in young women). Between 60 to 90 per cent of young people who attempt suicide are depressed. Rates of suicide among young men aged 15-24 have tripled since the 1960s and doubled for young women. For every suicide of a young man, there are an estimated 30 to 50 attempts, for every suicide of a young woman there are estimated to be over 150 to 300 attempts (Glover et al. 1998; Victorian Suicide Task Force 1997). Suicide attempts are more prevalent among depressed young people than among those suffering from other psychiatric disorders (Kovacs, Goldston & Gatsonis 1993)

Young offenders comprise a significant group of young people who are distressed and often suffer poor mental health. In 1997, 1200 young people aged 10-21 were clients of Victoria's juvenile justice system. These young people often have experienced abuse, have depressive disorders, made suicide attempts, are drug and alcohol users, or have had a psychiatric illness (Victorian Suicide Task Force 1997). Studies of adolescents in custody for repeated acts of delinquent behaviours and juvenile crime noted significant levels of clinical depression (NHMRC 1997). Other common features include severe family problems, a history of physical or sexual abuse and neglect, severe material disadvantage, long-standing learning and educational difficulties,

poor self-esteem, and social and cultural isolation. Overt and covert racial prejudice and societal marginalisation may contribute further to some young people's experiences of loss and consequent risk for depressive disorder.

The Mental Health Promotion and Prevention National Action Plan (1999) has identified Indigenous young people, young people living in rural and remote communities, and young people whose families or communities are experiencing adverse life events as high risk groups requiring specific strategies for intervention.

Other issues identified as affecting the mental health of young people include:

- **sexuality**

Sexuality is considered to be a key issue affecting young people's mental health. However, little information is available about adolescent sexual activity (Cubis 1992). A national report on same-sex attracted young people reported that large numbers of young people experience difficulties associated with their sexuality. These difficulties were expressed in terms of abuse by others (particularly at school), a lack of access to accurate information about sex and sexuality relevant to them, and a higher rate of illegal drug use than the general population of young people (Hillier et al. 1998).

- **drug use**

Drug use is strongly associated with mental health, with much of the literature indicating that drug use can precipitate mental ill health and that mental ill health can also lead to drug consumption. It is the legally available and socially acceptable drugs that are most often implicated in harmful substance use by adolescent Australians (Cormack in Kosky et al. 1992).

- **violence**

Violence against children and young people is strongly linked to mental health problems. An ABS survey of violence against women found that young women experienced significantly higher rates of both physical and sexual violence than any other age group surveyed (ABS 1996). Abuse of children and adolescents is often concealed. This may be particularly true with respect to sexual abuse which is thought to be the least frequently reported form of abuse (Mathias in Kosky et al. 1992). It is estimated that 34% of adolescents in outpatient treatment have experienced physical abuse while 44% have suffered sexual abuse (Victorian Suicide Task Force 1997).

- **discrimination**

Discrimination on grounds such as race, gender, sexuality and disability can cause mental distress in young people by undermining self-confidence and reducing opportunities at school, work and socially (Health Education Authority 1998).

- **poverty and social hardship**

Poverty and social hardship greatly affect children's and young people's mental wellbeing. Homelessness is linked to social marginalisation, lack of physical security and financial worries, and depression, anxiety and emotional problems are common (HEA 1998).

Factors Promoting Mental Health in Young People

There is general consensus that young people's mental health status is the product of a number of influences. The first report of the National Stocktake of Early Intervention Programs (1998) identifies factors which are thought to promote and protect young people's mental wellbeing. These factors include:

- access to appropriate levels of income;
- the promotion of attachment and belonging;
- supportive networks;
- good relationships with one or more parents;
- sound psychosocial development;
- enhancement of life skills (eg conflict resolution, anger management and problem solving);
- promotion of social skills;
- enhancement of coping skills;
- opportunity for control.

The NHMRC also identifies many of these factors, with the addition of being employed as a possible protective factor against the development of depression (NHMRC 1997). The Gatehouse Project has also made a considerable contribution to our understanding of mental health determinants relevant to young people. Their current study indicates significant links between social connectedness, positive regard, security and emotional wellbeing (Glover et al. 1998).

Issues to Consider when Developing Mental Health Promotion Activity

Priority for mental health promotion activities should be given to those initiatives that:

- focus on increasing social connectedness, positive regard and security in young people;
- foster community based initiatives for socially isolated individuals and communities, or for individuals experiencing high stress due to adverse personal, economic or social circumstances;
- apply principles of community development;
- build on existing community based initiatives;
- develop inter-sectoral alliances;
- give structural support;
- provide information and training to foster good practice;
- foster positive working relationships with relevant professionals;
- provide education to increase awareness of key issues relevant to mental wellbeing.

These guiding principles have been adapted from those developed by the New Zealand Ministry of Health for its policy on mental health promotion for younger people and older adults (NZ Ministry of Health 1997).

Factors that promote mental health in young people:

Access to appropriate levels of income

Good relationships with one or more parents

Sound psychosocial development

Attachment and belonging

Enhancement of life skills

Enhancement of coping skills

Promotion of social skills

Opportunity for control

Supportive networks

OLDER WOMEN AND MEN

PLANNED MENTAL HEALTH PROMOTION ACTIVITY 1999-2002

Young People

Research

VicHealth, in partnership with relevant organisations, will advocate for and support the development of research which:

- increases understanding of factors which facilitate positive settlement experiences for new arrivals to Australia, with a particular focus on the factors which facilitate positive personal development and growth among younger people;
- evaluates the Communities That Care Program (an operating methodology for the identification of risk and protective factors at the local level).

Implementation Trials

VicHealth, in partnership with relevant organisations, departments and funding bodies will support:

- workforce development for teachers which is delivered within a Health Promoting Schools framework with a specific focus on mental health promotion;
- further development of a community based Health Promoting Schools program designed to pilot and strengthen community and school based activity in relation to mental health promotion;
- community driven pilot projects which build on and strengthen networks to promote social connection, inclusion and economic participation for young people;
- the identification of health promotion strategies for the promotion of mental health for young people in the juvenile justice system;
- statewide local government activity which increases access for young people to community arts and recreation projects which facilitate skill development, enhance social connectedness and highlight the positive aspects of diverse communities;
- in line with current investments, projects designed to increase access to physical activity for all young people, particularly young women;
- organisational development activity designed to increase access to and participation in education for young people who are new arrivals to Australia;
- activity which increases support available to young rural people regarding sexuality issues, in particular young gay and lesbian people who are experiencing discrimination;
- activity designed to enhance the enterprise, leadership skills and opportunities for young rural people.

Older Women and Men – A Rationale for Mental Health Promotion

There is considerable controversy about the use of the term 'older people'. Sometimes it is used to apply to levels of physical health and mobility and at others to chronological age. The category of 'older people' spans an age group from 55 upwards, and necessarily includes people who are actively participating at 90 years or 55 years, and those who are frail at 55 years or 90 years. Older people are not a homogenous group and ageing affects women and men differently. For this reason, the term 'older women and men' is used in this Plan. An understanding of the diversity of the group 'older women and men' also requires a recognition of the effects of social, political and economic variables on the process of ageing and mental health.

There are significant gaps in our understanding of the mental health status of older women and men due to ageism in the design of mental health surveys (Snowden, Draper, Chiu, Ames & Brodaty 1998). For example, the ABS health surveys do not provide information on depression experienced by older women and men (Kendig, Helme, Teshuva, Osborne, Flicker and Browning 1996). Moreover, the broader effects of ageism combined with other forms of discrimination on the mental health of older women and men still require further consideration by researchers.

Issues Affecting the Mental Health of Older Women and Men

Researchers now recognise that the ageing process is affected by different combinations of social, psychosocial and behavioural variables across the life span, with the dynamic interaction of these factors similar to any other time of life (Teshuva, Stanislavsky and Kendig 1997). In general, people's lifestyles and the conditions in which they live and work strongly influence their health and longevity. More specifically, poverty, stress, early life experience, social exclusion, work, unemployment, social support, addiction, food and transport have been found to have significant effects on the general health and wellbeing of individuals and communities (Wilkinson & Marmot 1998).

There is also strong evidence suggesting that higher rates of mental health problems in older people are associated with:

- institutionalisation;
- chronic illness (such as arthritis) and disability;
- cancer, stroke and other debilitating illnesses;
- caring for those with significant behavioural disturbance where there is little support or respite;
- bereavement;
- isolation or lack of social networks and supports (Commonwealth Department of Health and Aged Care 1999).

Other issues affecting the mental health of older women and men include:

- **adverse life events**

Adverse life events affect older people and these may include the effects of unemployment, crime victimisation and other traumatic stressors. Bereavement and loss may also be considered as adverse life events which severely affect mental health, in the shorter or longer term.

- **use of alcohol and other drugs**

Further research on the impact of drug and alcohol use on the mental health of older women and men needs to be undertaken. There is mounting evidence that women over 55 years use considerable quantities of tranquillisers. Men on the other hand have been found to depend upon alcohol use, particularly through the stresses of retirement (Foster 1997).

- **stereotyping and negative attitudes towards older women and men**

Stereotyping and negative attitudes towards older people and ageing, such as the belief that they are 'past it', creates and reinforces discrimination and denies older women and men opportunities. Such attitudes also contribute to a lack of self-esteem and self-belief among older women and men. Older women and men may also be affected by changes in social values which undermine or contradict deeply held beliefs about ageing (HEA 1999).

- **under-reporting of mental health problems**

The National Survey of Mental Health and Wellbeing 1998 found a relatively low level of mental health disorders among older people living in the community (6.1%). However, the survey excluded those living in nursing homes, hostels, hotels, boarding houses, special accommodation houses and hospitals. Of people aged over 65 years, 6.5% are accommodated in nursing homes and hostels, and at any one time 1.5% are in hospital. The prevalence of mental health disorders among residents of nursing homes and hostels and hospital inpatients is much higher than in the general community (Snowden et al. 1998). It should also be noted that there is significant under-reporting of depressive symptoms in older people generally (Snowden et al. 1998).

- **the need for different approaches to health promotion for different sub-groups**

Particular population groups of older women and men experience higher rates of mental illness and therefore require a targeted approach. For example:

- Aboriginal people and Torres Strait Islanders continue to experience much poorer health than the general population (Commonwealth Department of Health and Aged Care 1999). The general health of Indigenous Elders is strongly affected by dispossession, the effects of the removal of children and other experiences of colonisation. This has a profound impact on the standard of living among Indigenous people in Victoria and on their overall mental health (Family and Community Development Committee 1997).

- Older women tend to experience comparatively higher rates of chronic disease, disability and depression than men. High levels of mental ill health in older women are due principally to economic, political and social factors such as poverty. Poverty among older women is caused by over-representation of women in the part-time labour force (often due to carer responsibilities), or the difficulties associated with re-entering the paid workforce after undertaking child rearing. Occupational segregation of the labour force and the effects of interrupted employment histories on accumulation of superannuation entitlements also affect the level of poverty of older women (Family and Community Development Committee 1997).
- Carers report much poorer health and lower levels of emotional wellbeing than non-carers (Family and Community Development Committee 1997).
- Depression among older women and men has led to high rates of suicide in some groups. There is a significant trend towards suicide among older Victorian men (Victorian Suicide Task Force 1997).
- Mental health problems among older migrants are at significant levels, and higher rates of psychological morbidity exist among elderly migrants from non-English speaking backgrounds (Klimidis and Minas 1998). There are a range of mental health risk factors associated with the process of migration and acculturation. These include the pre-migration experience, factors associated with migration, and post-migration factors (Family and Community Development Committee 1997). The impact of racism on mental health cannot be underestimated, particularly as it affects access to services, the cultural relevance of services, and the overall diagnostic approach to illness among people who do not speak English (Minas, Silove and Kunst 1993).
- The health of populations living in rural and remote Australia is worse than that of those living in capital cities and other metropolitan areas (Matthers 1994). Many rural communities are disadvantaged by certain 'quality of life' indicators including low income, poor housing, and limited access to infrastructure, health and social services which have been identified as having a key impact on their mental health (Family and Community Development Committee 1997). Reduction of services and supports in rural areas has resulted in increasing burdens on rural Victorians, particularly the older population (People Together Project 1997; Family and Community Development Committee 1997).

Factors Promoting Mental Health in Older Women and Men

A multitude of interrelated factors affect a person throughout life and these may have a significant influence on general wellbeing and the need for care and support in older age. These determinants include socioeconomic status, educational level, employment opportunities, cultural background, gender, and health and lifestyle practices. The combined effect of events and circumstances that occur throughout the life-course affect wellbeing in later life (Family and Community Development Committee 1997).

The mental health determinants identified earlier in this document contribute to the overall maintenance of positive wellbeing. These may be complemented by the following determinants which relate to older women and men:

- the maintenance of independence and good health;
- participation in the workforce and positive transitions to retirement;
- contribution to and participation in community and cultural life, community connectedness and activities which generate social capital such as volunteering;
- health and physical activity, and the maintenance of independence;
- community infrastructure which facilitates activity and participation (such as housing, urban design and the physical environment);
- access to resources such as income and social support;
- safety and security (physical, social and emotional).

(Victorian Government 1999; RMIT et al. 1998.)

Issues to Consider when Developing Mental Health Promotion Activity

To 'add life to the years that have been added to life', the United Nations General Assembly adopted eighteen Principles for Older Persons on 16 December 1991 (Resolution No. 46/91). The principles were based on the five key principles of:

- independence
- participation
- care
- self-fulfillment
- dignity.

The Older Persons Taskgroup considers these principles should guide the promotion of mental health to older women and men. The aims of the International Year of Older Persons also should inform the planned activity. These aims are to:

- further promote to Australians, of all ages, the perception of ageing as an opportunity;
- assist in breaking down stereotypes and change attitudes to ageing;
- foster inter-generational activities and understandings;
- inform the community about the benefits of the National Healthy Ageing Strategy and other strategies promoting the mental health of older women and men;
- encourage government and non-government organisations to examine their policy directions and programs in order to be more inclusive and responsive to the needs of people of all ages;
- encourage support for family involvement in caregiving, both in younger people caring for older members of the family as well as grandparents caring for grandchildren.

Five key principles to 'add life to the years that have been added to life':

-
- **Independence**
-
- **Participation**
-
- **Care**
-
- **Self-fulfillment**
-
- **Dignity**
-

(United Nations General Assembly Resolution No. 46/91)

KOORI COMMUNITIES

PLANNED MENTAL HEALTH PROMOTION ACTIVITY 1999-2002

Older Women and Men

Research

VicHealth, in partnership with relevant organisations, will advocate for and support the development of research which identifies:

- mental health determinants relevant to older women and men;
- factors contributing to positive retirement for older women and men.

Implementation Trials

VicHealth, in partnership with relevant organisations, government departments and funding bodies, will place emphasis on consolidation of current mental health promotion activity through:

- contribution to the development of a database to provide information regarding current activity relevant to positive ageing;
- coordinating, resourcing, evaluating and documenting the 22 projects funded through the Positive Wellbeing Grant undertaken by VicHealth in conjunction with the Aged Care Branch of the Department of Human Services (DHS);
- extension of the current VicHealth/DHS project focusing on organisational capacity building designed to enhance access to appropriate support for older women who have experienced sexual violence;
- extension of two current VicHealth/DHS organisational and workforce development projects designed to increase older people's access to physical activity facilities.

VicHealth, in partnership with relevant organisations, government departments and funding bodies, will also develop the following future initiatives:

- statewide local government activity which increases access for older people to community arts and recreation projects which facilitate skill development, enhance social connectedness and highlight the positive aspects of diverse communities;
- staging of annual Active For Life small grants funding rounds designed to improve access to physical activity, recreation and social support for older people. The evaluation of the Active For Life funding program will include identification of the mental health impacts associated with the social interaction experienced by participants;
- supporting promotion of state legislation prohibiting discrimination on the basis of age and exploration of other methods to reduce ageism;
- local government workforce development activity challenging ageism and delivery of a local government based peer education program focusing on positive ageing.

Koori Communities – A Rationale for Promotion of Emotional and Spiritual Wellbeing

Colonisation, underpinned by the notion of terra nullius changed the lives of Aboriginal and Torres Strait Australians forever... it took away not just the land, the soul, the identity, the language and the spirituality of my people, but it took away the children, broke down family networks and left many people with no alternative other than to be embraced by grief, left feeling broken hearted, often welfare dependent, and suffering from socioeconomic disadvantage (Angus 1997).

Aboriginal people in Australia constitute a culturally rich and diverse population. There is no typical Aboriginal person or single voice of the Aboriginal people (Anderson, 1996). VicHealth acknowledges the diversity of the community and that the term Aboriginal includes Aboriginal and Torres Strait Islander peoples. In this document the term Koori refers to the Aboriginal people who are the traditional owners of the lands of south eastern Australia. This is a generic term and is not intended to be imposed on Indigenous people in Victoria who do not identify as Koori.

As 'one people – many cultures' Indigenous communities have their own histories, cultures and community concerns (ATSIC 1994). Each community has a specific set of cultural values and traditions with particular responsibilities for knowledge and practice in health and wellbeing as part of women's, men's, and family business, in addition to the wisdom of Elders. Belonging to the land is fundamental to the cultural life, history, spiritual wellbeing and identity of Indigenous people. Family and kinship groups are based on complex systems of spiritually based language groups, which determine relationships, obligations and rights of individuals (VACCHO 1997).

The Aboriginal people of Victoria have a unique history. Because of the productive nature of the land and the ready availability of food they did not have the extensive purposeful nomadic lifestyle of the people of northern Australia. Considerable amounts of time were spent in culturally enriching pursuits, which included music, dance, artwork and story telling (Atkinson 1997). Mainstream reporting and portrayal of Aboriginal people has often ignored these and many other strengths and successes of communities and their members, while concentrating on negative stereotypes.

The Aboriginal people of Victoria and Southern New South Wales have experienced the most extensive, unrelentingly violent and culturally damaging contact with non-Aboriginal people since White settlement. The sequential government policies of violent dispossession of lands, denial of access to natural and cultural resources, segregation, assimilation and cultural genocide have had devastating consequences on the health, spiritual wellbeing and family and kinship frameworks of Aboriginal people.

The spiritual and psychological impact of dispossession has resulted in generations of grief and outrage, the denial of hope and, for many, a continual reinforcement that they have little control over their lives (HREOC 1997).

Research and practice experience demonstrates that Aboriginal people in Australia still deal with gross disadvantage with regard to access and equity within social, health, welfare, income, education, housing and education sectors. As acknowledged in the Bringing Them Home Report:

The present plight, in terms of health, employment, education, living conditions and self-esteem, of so many Aborigines must be acknowledged as largely flowing from what happened in the past. This dispossession, the destruction of hunting fields and the devastation of lives [are] all related. The new diseases, the alcohol and the new pressures of living were all introduced (HREOC 1997).

The report of the National Inquiry into the Human Rights of People with a Mental Illness (HREOC 1993) proposes that mental illness among Aboriginal people cannot be understood in the same terms as mental illness among non-Aboriginal Australians.

Aboriginal people experience the same rate of mental illness such as schizophrenia, bipolar disorder and organic states as non-Aboriginal people. However, Aboriginal people experience proportionally higher rates of depression, grief, sadness, stress and trauma, suicide and self-harming behaviour, anxiety states and alcohol related psychosis than non-Aboriginal people (Swan & Raphael 1995; McKendrick, Cutter, Mackenzie and Chiu 1992). Despite this, proportionally fewer Aboriginal people have used mainstream mental health services than in the overall population (HREOC 1997; Hunter 1995).

In recent years Aboriginal people have adopted the holistic term 'emotional and spiritual wellbeing' to describe mental health issues in their communities (Swan & Raphael 1995).

EMOTIONAL AND SPIRITUAL WELLBEING IN KOORI COMMUNITIES

Aboriginal spiritual and emotional health is viewed in a 'whole health' perspective, encompassing physical, social, emotional and cultural wellbeing, with acknowledgement of history and past experiences as integral to all approaches in health care. Spiritual and emotional health is described as being owned by Aboriginal people, enhanced by cultural practices and recognising traditional healers (VACCHO 1996).

The major institutional factors which will drive the improvement of health outcomes for Aboriginal people include:

- the need for Aboriginal health and community services to be community owned and community controlled;
- the importance of a strong Aboriginal voice, which is critical to the quality and effectiveness of health care services provided to Indigenous people;
- the need to develop and negotiate strong complementary roles for mainstream government health and community services with Aboriginal community controlled health organisations.

VISION STATEMENT

The promotion of positive emotional and spiritual wellbeing in Koori communities is holistic, involving individuals, families, communities and the broader social environment.

Each person must be able to access resources to address inequities, work toward personal reconciliation and, with others, take action that responsibly promotes the cultural safety, growth and strength of our communities.

Strategies to promote the positive emotional and spiritual wellbeing of Victoria's Koori communities will:

- recognise the centrality of land, culture and community;
- acknowledge past government practices of violence and cultural genocide;
- embody the principles of self-determination by requiring participation and partnership with Koori people in all aspects of planning, development, community ownership and control.

Issues Affecting the Emotional and Spiritual Wellbeing of Kooris

The mental health care of Aboriginal people is neither esoteric nor exotic ... it is the psychiatry of endemic and unrelenting poverty, and profound disadvantage (Hunter 1995).

A range of factors had a profound effect on the emotional and spiritual wellbeing of Aboriginal people. These include:

- the forced removal of children and family disintegration;
- social and economic disadvantage;
- poor health overall;
- racism;
- substance abuse.

THE FORCED REMOVAL OF CHILDREN AND FAMILY DISINTEGRATION

In common with non-Aboriginal people, social and economic factors underpin the mental health of Aboriginal people. However, the particular effects of the Australian government's history of enacted policies of isolation, protection, assimilation and integration have resulted in up to four generations of families experiencing forced removal of children and family disintegration. It has been estimated that Victoria has had the highest rate of forced removal of children, with up to 90% of families affected (VACCHO 1998).

SOCIAL AND ECONOMIC DISADVANTAGE

As described earlier, mental ill health is strongly linked to variables such as limited social connectedness, and other social and structural factors such as poverty and unemployment. It must be acknowledged that while poverty, unemployment and limited access to adequate housing have significant impact on the health and wellbeing of the general population, Aboriginal people's experience of these issues is disproportionately high. Indicators of social and economic disadvantage among the Indigenous people of Australia include:

- The mean income for Aboriginal people in 1994 was less than 66% of the national figure.
- The national unemployment rate of Aboriginal people is 30.8% compared to 11.7% in the overall population.

Factors for Consideration when Promoting the Emotional and Spiritual Wellbeing of Kooris

- Aboriginal people have lower levels of participation in education. For example, the year 12 retention rate for Aboriginal people in 1994 was 25% compared to 75% in the non-Aboriginal population.
- Aboriginal people have much higher rates of substandard housing and overcrowding with 64% renting their homes, compared to 25% in the non-Aboriginal population (ATSIC 1994).

HEALTH STATUS

Aboriginal people experience poorer health status than non-Aboriginal people. For example:

- Infant and perimortality rates are three times those of the overall population.
- The life expectancy at birth for Aboriginal women is 20 years less than the national figure and 18 years less for Aboriginal men.
- Young and middle aged Aboriginal people die at rates 10 times higher than non-Aboriginal people.
- The major causes of death are diseases of the circulatory system, injury and poisoning, respiratory disease and neoplasms.
- Approximately 10% of the adult Aboriginal population have diabetes and the death rate from diabetes is 12-17 times the rate of the overall population.
- Alcohol is the direct cause of 10% of Aboriginal deaths, 3-4 times the proportion in the overall community.

RACISM

The Health Education Authority has documented the full impact of racism on mental health and wellbeing (HEA 1999). An abundance of evidence of social and structural racism perpetrated against Aboriginal Australians can be found in a range of reports which have documented the voices of those people who have experienced or witnessed these practices. This includes:

- increased policing and incarceration of Aboriginal people, particularly young people, and their concomitant high rates of death in custody (The Royal Commission into Aboriginal Deaths in Custody 1991);
- cultural misinterpretation, misdiagnosis and inappropriate treatment including unnecessary incarceration (HREOC 1993);
- forced removal and cultural genocide (HEREOC 1997).

SUBSTANCE USE

In Koori communities there is a strong relationship between mental illness and substance use, and a strong correlation between mental illness and separation from family and dislocation as children. The role of alcohol, introduced at the time of colonisation, has also had a devastating and enduring effect on Aboriginal communities (Hunter 1995).

Combined with social and economic factors, the key issues affecting the emotional and spiritual wellbeing of Kooris are:

- Many adults driven by distress and grief are searching for their identity and their families.
- Gaps in knowledge and skills where many parents are struggling to care for their children without having experienced any real parenting themselves.
- Men's traditional roles and responsibilities have been eroded, they are not able to be decision makers and heads of families.
- Women's roles remain as carers of children and elderly, often on their own as sole carers.
- Family violence is a great concern in communities, particularly against women and children (Andrews & Gilmore 1995; Farnham 1999).

The National Aboriginal Mental Health Policy and Plan (1996) proposes priority areas for initiatives which strengthen and support the emotional and spiritual wellbeing of Aboriginal communities. These include addressing trauma and grief, healing and reconciliation, violence, suicide and self-harm, and substance abuse among families, young people, women, men and Elders.

Historically, discourse by non-Aboriginal people on the disadvantage of Aboriginal people has lacked acknowledgement of the ownership of Aboriginal business by Aboriginal people. While the issues related to disadvantage are discussed frankly within communities, it is important that the mainstream ensures sensitivity and respect when discussing Aboriginal issues. Similarly, there is a need for acknowledgement of the skills and competence in the communities to address issues.

Issues to Consider when Developing Emotional and Spiritual Wellbeing Activity

Nine guiding principles were developed by the Commonwealth Government in the National Aboriginal and Torres Strait Islander Mental Health Policy for Australia to inform policy development for all Aboriginal health initiatives. The principles are that:

- the Aboriginal concept of health is holistic;
- self-determination is central;
- Aboriginal experiences of trauma and loss must be recognised;
- culturally valid understandings must shape the provision of services;
- the human rights and the Indigenous rights of Aboriginal people must be affirmed;
- the impact of racism and stigma must be acknowledged;
- the centrality of kinship must be recognised;
- there must be recognition of different communities and their different needs;
- the strengths of Aboriginal people must be recognised (Swan & Raphael 1995).

These overarching principles have been endorsed and supported by the Koori Taskgroup as the principles which should inform the development of strategies to address the promotion of emotional and spiritual wellbeing of Koori people in Victoria.

The planned activities will therefore:

- be developed and implemented by Koori people;
- link with existing activity in Koori health and community services;
- build capacity in Koori communities for the sustainability of the programs and activities;
- support partnerships between Koori communities and the mainstream, with preferential support to the community end of the partnership;
- ensure that the mainstream takes responsibility for discrimination;
- promote self-determination for all individuals and communities.

ACTIVITY TO PROMOTE EMOTIONAL AND SPIRITUAL WELLBEING 1999 – 2002

Koori Communities

Research

VicHealth, in partnership with relevant organisations, will advocate for and support the development of mechanisms which:

- ensure that research which focuses on Koori health will address issues and priorities which will make a difference in Koori communities;
- are developed, resourced and owned in partnership with the relevant communities.

VicHealth will also continue to support the work of the Koori Health Research and Community Development Unit recently established within the University of Melbourne.

Implementation Trials

VicHealth, in partnership with Koori organisations, government departments and funding bodies will support activities which:

- address the underlying causes of ill health in Koori communities and the structural issues which affect emotional and spiritual wellbeing, for example unemployment, lack of sustainable access to education and economic development (these examples are not exclusive);
- support the ongoing development of the capacity of community controlled organisations to conduct program and project evaluation;
- support the building on to current models of best practice;
- facilitate the strengthening of cultural identity and the reinforcing of culturally supportive environments;
- support the building of positive relationships within family and community contexts;
- acknowledge and support diversity within communities;
- support education of all non-Aboriginal teachers and children in Aboriginal history and culture;
- support ongoing review and reform of government policies and programs which have the potential to promote the emotional and spiritual wellbeing of Koori people/communities.

NEW ARRIVALS TO AUSTRALIA

The mechanisms to implement these activities will:

- include development of funding Guidelines which are informed by the vision statement, principles and project outlines;
- call for Expressions of Interest for larger projects and programs;
- support development and implementation of activities identified as priorities.

Examples of the types of projects which could be developed include the Rumbalara Football Netball Club and the Mungabareena Aboriginal Cooperative.

Rumbalara Football Netball Club

- has a holistic philosophy and vision where community involvement and participation in sport provides a means of strengthening the physical, emotional, spiritual and cultural wellbeing of the members of the Goulburn Valley Aboriginal communities.
- has attracted funding for a range of programs which address issues of emotional and spiritual wellbeing of the communities. These include reconciliation issues with the non-Aboriginal community, dealing with racism, building self-esteem of young people and activities to strengthen cultural and family networks.

Mungabareena Aboriginal Cooperative

The Koori Cultural Regeneration Project, conducted in partnership between Mungabareena Aboriginal Cooperative in Wodonga and NEWomen (Goulburn North Eastern Women's Health Service) helped strengthen understanding by sharing cultural knowledge between the local Koori community and the broader community. Activities involved people of all ages in learning from the Elders, and participating in music, dance and food activities.

New Arrivals – A Rationale for Mental Health Promotion

A significant proportion of people who entered Victoria through the Migration and Humanitarian Programs originated from countries in which English is not the main language spoken and from cultural backgrounds which are very different from the Anglo-Celtic tradition (Department Immigration and Multicultural Affairs 1999). While most new arrivals ultimately settle very successfully in Australia and make a productive contribution to Australian cultural, social and economic life, the process of adjustment to a new country may be stressful for many entrants. Settlement is also a time when new arrivals may have limited access to the resources required for mental health.

Research and practice experience suggests that if support is offered at an early stage in the settlement period there are significant prospects for preventing the development of mental health problems. Similarly, early intervention greatly enhances the potential for identifying and addressing existing difficulties to ensure they do not become enduring barriers to successful settlement and the achievement of mental wellbeing (Aroche & Hartgerink 1998).

This approach is particularly important for children and young people, offering the potential to assist at both an early stage of settlement and at an early stage of their development (Victorian Foundation for Survivors of Torture VFST 1996). It also has application for the significant proportion of new arrivals (in particular those entering through the Humanitarian Program) who have been subject to extreme human rights abuses and concomitant social and economic deprivation prior to migration. The mental health consequences of these experiences may be both long-term and transgenerational. Targeting mental health promotion to this group will enhance their chances of successful settlement and recovery, and go some way toward increasing the capacity of the Victorian community to play a positive role in supporting them in this endeavour.

Issues Affecting the Mental Health of New Arrivals

THE PRE-MIGRATION EXPERIENCE

A significant proportion of new arrivals to Australia are from conflict zones around the world. Entering primarily through the Humanitarian Program and Family Stream of the Migration Program, many of these entrants have been exposed to extreme stress and disruption prior to migration (VFST 1998a, 1998b, 1998c; Muse 1994; Moussa 1993; Burke & MacDonald 1994). This may have included:

- torture, including sexual and psychological violation and periods of incarceration;
- prolonged periods of persecution involving the denial of basic human rights;

- forcible removal from their homes and land and cultural dispossession;
- prolonged periods as a displaced person or in a refugee camp involving deprivation of the basic resources required for survival (eg health care, employment, food and shelter);
- separation from family members, often through death or disappearance.

This exposure is not confined to adults. Many children and adolescents from such 'refugee-like' situations have witnessed horrific events and suffered the effects of dislocation and deprivation. In some regimes they have been the specific targets of torture (UNICEF 1996).

Those from refugee-like situations experience rates of certain mental illnesses, in particular post traumatic stress disorder and anxiety and depressive disorders, that well exceed the rates for the general population (Silove 1994; Simpson 1993; Mollica, Wyshal and Lavelle 1987; Kinzie, Friedrickson, Ben, Fleck and Karis 1984). The effects may be both long-term (Creamer 1997; Kuch 1992) and transgenerational (Harkness 1993).

These pre-migration experiences may exacerbate the stresses associated with settlement for a number of reasons:

- The psychological sequelae of exposure to trauma and torture may affect entrants' capacity to deal with the tasks of settlement (VFST 1998a).
- For many of these entrants, migration was hurried, unplanned and forced, with losses being multiple, extreme and occurring in traumatic circumstances.
- Refugees do not have the option of returning home in the event that settlement is unsuccessful.
- Entrants from refugee-like backgrounds face the stress of news of ongoing victimisation and deprivation faced by friends and relatives in their homelands.
- The experience often has a disruptive impact on education and employment which may serve to place entrants, particularly children and young people, at ongoing disadvantage in education and the labour market (Rutter 1994).
- Loss of and separation from family members means that many entrants from refugee-like backgrounds lack the protective influence of family support. This is particularly the case for sole parents and for young people, many of whom arrive unaccompanied or without members of their immediate family.
- Refugee communities may be limited in their capacity to convey the protective effects of personal relationships and social support. This may be due variously to the emergent nature of these communities, the collective consequences of exposure to trauma and torture, and divisions within communities, often stemming from conflict in the country of origin.
- Entrants from refugee-like situations have relatively poor physical health status (Lehn 1997).

These difficulties are compounded for those from refugee-like situations who apply for refugee status on their arrival in Australia having arrived on a temporary visa or without a valid entry permit (Silove et al. 1997; Sinnerbrink, Silove, Manicavasagar, Steel and Field 1996). Known as asylum seekers, this group face constraints on their entitlements to health care and social support in the period during which their refugee status is being determined. The determination process may be both stressful and prolonged, with applicants facing the constant threat of forced repatriation.

SETTLEMENT ISSUES

New arrivals from culturally and linguistically diverse backgrounds may be vulnerable to a number of adverse influences on their mental health, including:

- limited proficiency in English, contributing to social isolation and serving as a barrier to accessing many of the resources required for mental health (Westemeyer 1986);
- the practical demands of adjusting to a new country which may be experienced as overwhelming (eg learning a new language, using public transport, negotiating health and welfare systems) (Lin 1986);
- grief associated with the loss of the land, culture and family and friends left behind (Lerner, Mirsky and Barasch 1994);
- adjusting to new and sometimes conflicting cultural values of the host community. This is a particular issue for women and young people (Ferguson 1991; Lin 1986);
- a reduction in the opportunities to engage in recreation, associated with the adjustment to a more sedentary lifestyle in Australia and with barriers to participation in physical activity (Wilson 1998).

These stresses may be particularly marked for arrivals from countries in which there are significant social, cultural and economic differences between Australia and their country of origin (eg entrants from rural or tribal communities). These entrants may face the double jeopardy of adjusting to both modernisation and cultural gaps (Lin 1986).

ACCESS TO RESOURCES

At the same time, new arrivals may have limited access to resources for mental health. They:

- experience relatively high rates of unemployment and underemployment (Collins 1998; Watson 1998);
- are concentrated in those areas of the labour market characterised by poor working conditions and remuneration and job insecurity (Watson 1998);
- are over-represented among the poor and experience associated socioeconomic disadvantage (Mitchell 1998; Saunders 1998);
- are more likely to live in substandard or insecure housing (Francis & Price 1996; Ekblad, Ginsburg, Jansson and Levi 1994);
- are vulnerable to racism and discrimination (HREOC 1991; Lin 1989). In addition to the impact on self-esteem, belonging and personal safety, discrimination may compromise access to many of the resources required for mental health such as education and employment (Collins 1998; Watson 1998; HREOC 1991);
- may have limited access to support from family and friends and community support networks and services (Westemeyer 1986). This is particularly the case for entrants from those communities that are small and not well established in Australia.

Factors Promoting Mental Health in New Arrivals

There is general consensus in the literature that an optimum health promoting environment is one in which new arrivals are able to access the resources of mainstream society, while at the same time maintaining their cultural and religious integrity (Ferguson & Browne 1991). The re-establishment of safety, autonomy and control is seen as particularly important for entrants from refugee-like situations (VFST 1998a).

While there is a dearth of systematic research on the specific factors assisting new arrivals to attain optimal mental health, the following are identified in the literature :

- acquisition of English;
- the ability to access, understand and negotiate basic systems and resources for survival (eg health care, entitlements, employment, income security benefits, transport and banking);
- access to income security measures, housing and employment;
- a positive reception by the host community, including the absence of both community and institutional forms of discrimination;
- an environment in which cultural, religious and ethnic diversity is valued and promoted;
- equality of access to resources for mental health including education, employment and housing;
- the availability of social support through either the host or ethnic community;
- opportunities for recreation, particularly for children;
- the availability of meaningful personal relationships through family and friendships;
- support to deal with the consequences of trauma and torture where required;
- an environment in which there is a visible commitment to the protection and preservation of human rights (VFST 1998a; Ferguson & Browne 1994; Marsella, Bornemann, Ekblad and Orley 1994).

Issues to Consider when Developing Mental Health Promotion Activity

With the preceding information in mind, the New Arrivals Taskgroup decided priority for activities designed to promote mental health should go to those that:

- promote ethnic, cultural and linguistic diversity as a social value in both the ethnic and wider communities;
- assist new arrivals to access basic systems and resources required for settlement (eg language classes);
- redress the economic disadvantage experienced by new arrivals by enhancing their access to employment, housing, education, income and other resources;
- promote equality of access to the economic, social and cultural resources of Australian society (such as employment, housing, sporting and leisure facilities);
- seek to eliminate discrimination based on gender, race or ethnic, cultural or religious background;
- enhance access to formal and informal support networks, particularly by survivors of trauma and torture;
- enhance the capacity of both ethnic and host communities to provide social contact and support to new arrivals;
- promote and protect human rights in Australia and internationally;
- seek to reach groups of new arrivals with particular needs, in particular single parents and young people (especially those arriving unaccompanied by their immediate family).

To optimise the prospects for intervening early in the settlement period, individual and group interventions should be targeted to those entrants who have recently arrived in Australia.

To both optimise the prospects for intervening early in the settlement period and for reaching those at particular risk, community level interventions should be targeted to:

- communities comprising a large number of recent entrants from refugee-like situations, including those arriving as asylum seekers;
- communities in which there are substantial cultural, social and economic differences between the country of origin and Australia;
- emergent communities experiencing a high level of social disadvantage.

Appendix 1: Taskgroup Members

PLANNED MENTAL HEALTH PROMOTION ACTIVITY 1999-2002

New Arrivals to Australia

Research

VicHealth, in partnership with relevant organisations, will advocate for and support the development of research which:

- increases understanding of factors which facilitate positive settlement experiences for new arrivals to Australia with a particular focus on the factors which facilitate positive personal development and growth among younger people;
- assists in the development of culturally appropriate tools for the measurement of wellbeing.

Implementation Trials

VicHealth, in partnership with relevant organisations, government departments and funding bodies, will support:

- workforce development designed to increase the capacity of English language centres and relevant primary schools to respond to the emotional needs of children who are new arrivals to Australia;
- organisational development activity designed to increase access to appropriate education for young people who are new arrivals to Australia;
- activity which increases access to participation in sport and recreation for young people who are new arrivals to Australia, particularly young women;
- activity which addresses discrimination within sport including fostering sporting environments which are inclusive and that value diversity;
- economic and community development activity designed to improve skill levels and access to work for new arrivals to Australia;
- community and organisational capacity building projects which reduce isolation and provide opportunities for social interaction for individuals and families who are new arrivals to Australia;
- workforce development designed to increase the capacity of general practitioners to respond to the emotional needs of individuals and families who are new arrivals to Australia;
- statewide local government activities which increase access for new arrivals to community arts and recreation projects and that facilitate skill development, enhance social connectedness and highlight the positive aspects of diverse communities.

Rural Communities Taskgroup

Ms Liz	Callaghan	Department of Human Services, Rural Health Branch
Ms Suzanne	Cooper	Ovens & King Community Health Service
Mr Barry	Hahn	Victorian Council of Social Services
Mr Sandy	Geddis	Regional Department of Human Services
Dr Jane	Greacen	Rural WorkForce Agency Victoria
Mr Don	Gunn	Midland Express
Mr Henk	Harberts	La Trobe Shire Council
Mr Lenny	Jenner	Sport and Recreation Victoria
Ms Dominique	La Fontaine	Municipal Association of Victoria
Ms Robyn	Mason	Centre Against Sexual Assault, Ballarat
Mr Peter	Matthews	Victorian Arts Council
Ms Fiona	Mercer	Mortlake Health Service
Ms Trish	Mundy	VicHealth (Chairperson)
Ms Mary	Quinn	City of Ballarat Healthy Community Program
Ms Dianna	Rice	Rural Women's Network
Ms Margaret	Smythe	Department of Human Services, Public Health Division
Ms Jo	Wainer	(Writer)
Ms Genevieve	Timmons	Lance Reichstein Charitable Foundation
Dr Airlie	Worrall	Victorian Farmers Federation

Young People Taskgroup

Ms Monica	Bensberg	Department of Human Services
Mr Jarrard	Binks	Youth Adviser
Ms Jenny	Coate	Children's Court, Coordinating Magistrate
Cr Sara	Coward	Maribyrnong City Council
Ms Rhonda	Cumberland	(Writer)
Ms Gillian	Duncan	Sport and Recreation Victoria
Ms Shirley	Freeman	Malmsbury Juvenile Justice Centre
Mr Lindsay	Gaze	Victorian Basketball Association
Mr David	Green	Public Advocate
Ms Libby	Mears	Department of Human Services, Public Health Division

Ms Penny	Mitchell	Australian Institute of Family Studies
Ms Fran	O'Toole	Department of Human Services, Primary Health Program
Dr Gill	Parmenter	Department of Human Services, Youth & Family Services Division
Prof George	Patton	Centre for Adolescent Health, Royal Children's Hospital
Mr Ric	Pawsey	Child & Adolescent Mental Health Services, Regional Officer
Ms Sanya	Reid-Smith	Youth Adviser
Ms Yvonne	Robinson	North East Health Promotion Centre (Deputy Chairperson)
Prof Lawrence	St Leger	Deakin University (Chairperson)
Mr Bill	Stronach	Australian Drug Foundation
Ms Maree	Tehan	Jesuit Social Services
Mr Barrie	Thomas	The Body Shop
Ms Irene	Verrins	Department of Education: Connect Project
Mr Mark	Wilkinson	City of Darebin
Prof Joanna	Wynn	University of Melbourne, Centre for Youth Research

Older Women and Men Taskgroup

Prof Connie	Benn	Broadmeadows Community Health Service
Ms Rosemary	Calder	Department of Human Services, Aged Care Branch
Prof Edmond	Chiu	Aged Persons Mental Health Service, St George's Health Service
Mr Phillip	Dunn	Barwon Psychiatric Services
Ms Susan	Feldman	University of Melbourne, Alma Unit
Mr Nick	Foa	Maroondah City Council
Prof Peter	Foreman	La Trobe University, Lincoln Gerontology Centre
Ms Claire	Hargreaves	Municipal Association of Victoria
Prof Helen	Herrman	St Vincent's Mental Health Service (Chairperson)
Ms Susan	Holmes	Sports Federation of Victoria Inc.
Ms Therese	McCarthy	VicHealth (Writer)
A/Prof Andrew	MacKinnon	Mental Health Research Institute
Ms Vivienne	McCutcheon	Co-Alition 99 (Victoria)
Ms Megan	McQueenie	Mental Health Foundation of Victoria
Ms Natasha	Pearce	Department of Human Services
Ms Pat	Reeves	Council of the Ageing

Ms Delys	Sargeant	Co-Alition 99 (Australia)
Mr Noel	Sharp	Sport and Recreation Victoria

Koori Communities Taskgroup

Dr Ian	Anderson	University of Melbourne (Chairperson)
Mr Jim	Berg	Koorie Heritage Trust
Ms Salina	Bernard	VACCHO, Victorian Regional Spiritual Healing Training Centre
Mr Paul	Briggs	Koori Resource and Information Centre
Mr Alan	Brown	VACCHO
Ms Dot	Campbell	Writer
Mr Shaun	Coade	VACCHO
Mr Michael	Fisher	Koori Heritage Trust
Mr Ron	James	Department of Human Services, Koori Health Unit
Mr Mark	Lutschini	OATSIH
Mr Tony	McCartney	Victorian Aboriginal Health Service
Ms Robynann	Morgan	OATSIH
Ms Kerry	O'Neill	Maribyrnong City Council
Mr Mark	Rose	RMIT University
Ms Angelina	Tabuteau	Department of Human Services, Protection and Care
Ms Lisa	Thorpe	Resource Unit for Indigenous Mental Health Education and Research (RUIMHER)
Ms Nancy	Walke	Department of Human Services, Victorian Director, OATSIHS
Ms Trudy	Wyse	The Stegley Foundation

New Arrivals Taskgroup

Mr Paris	Aristotle	Victorian Foundation for the Survivors of Torture
Mr Hass	Dellal	Australian Multicultural Foundation
Ms Rita	Faelli	National Police Ethnic Advisory Bureau
Ms Alison	Fraser	City of Melbourne
Prof Sandra	Gifford	Deakin University
Ms Mirta	Gonzales	Centre For Culture, Ethnicity and Health
Ms Carmel	Guerra	Ethnic Youth Issues Network

List of abbreviations used

Ms Stephanie	Lagos	Preston Migrant Resource Centre
Ms Janice	Lane	VicHealth (Chairperson)
Mr Sam	Lipski	Pratt Foundation
Ms Joann	McKenzie	Department of Immigration, Local Government and Multicultural Affairs
Prof Harry	Minas	Victorian Transcultural Psychiatry Unit
Ms Anna	Moo	Royal Women's Hospital
Ms Sue	Nattrass	Melbourne Festival Director
Dr John	Stanton	Department of Human Services, General Practice Unit
Ms Cathy	Walsh	Victorian Red Cross
Ms Kim	Webster	(Writer)
Ms Marg	Welsh	City of Port Phillip
Ms Jenny	Wills	Municipal Association of Victoria

ABS	Australian Bureau of Statistics
ACTU	Australian Council of Trade Unions
AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
APHA	Australian Public Health Association
ATSIC	Aboriginal and Torres Strait Islander Commission
CPHA	Canadian Public Health Association
DHS	Department of Human Services, Victoria
DIMA	Department of Immigration and Multicultural Affairs
HEA	Health Education Authority, London
HREOC	Human Rights and Equal Opportunity Commission
MHPPNAP	Mental Health Promotion and Prevention National Action Plan
NHMRC	National Health and Medical Research Council
OATSIH	Office of Aboriginal and Torres Strait Islander Health Services
PRISM	Program of Resources, Information and Support for Mothers
RUIMHER	Resource Unit for Indigenous Mental Health Education and Research
TRANSACT	Torture Rehabilitation and Network Services ACT Inc.
UNICEF	United Nations International Children's Education Fund
VACCHO	Victorian Aboriginal Community Controlled Health Organisations Inc.
VFST	Victorian Foundation for Survivors of Torture
VicHealth	Victorian Health Promotion Foundation
WHO	World Health Organization

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