Mental Health & Wellbeing Unit
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VicHealth Mental Health Promotion Evidence Review
A Literature review focusing on the VicHealth 1999-2002 Mental Health Promotion Framework

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INTRODUCTION

The Victorian Health Promotion Foundation, VicHealth, is an independent statutory body established in 1987. VicHealth works towards the development of innovative responses to the complex social, economic and environmental forces that influence the health of all Victorians. VicHealth has a particular focus on a flexible, responsive and evidence-informed approach to working with partners from across different sectors in the community to create environments which improve population health.

In 1999, VicHealth established a framework for the development of activity relevant to the promotion of mental health and wellbeing. The VicHealth Mental Health Promotion Framework identified three determinants of mental health: 'social connectedness', 'freedom from discrimination and violence', and 'economic participation'.

In 2003 the Sydney Health Projects Group was commissioned to undertake a review of the literature pertaining to the Framework – particularly literature published after 1998, when the documentation to inform its development was first compiled. This report provides a summary of the evidence reviewed and a discussion of the implications of the research for consideration by VicHealth.

Review focus

The project brief was to provide VicHealth with an orientation to the relevant literature, and identify 'sign-posts' to the main findings, ongoing debates, and gaps in knowledge.

The review addressed two broad questions:

1) What published information is available about the determinants of mental health, given priority by VicHealth, and the relationships between these determinants and mental health?
2) What is the evidence for potential interventions to address these determinants and promote mental health?

Review methods

Literature searching

The reviewers examined electronic databases of published literature (i.e. Medline, Psychinfo, Sociofile, Cinahl, Embase, Cochrane, APAIS-Health, ATSIHealth, EBM reviews, Health & Society Database); internet websites using the 'Google' search engine; documents recommended by word of mouth via VicHealth; and reference lists from documents already sourced using the above methods.

The following search terms were used, starting with the determinants of mental health identified in the 1999-2002 VicHealth Mental Health Promotion Framework:

Social Connectedness	*Freedom from discrimination*	*Economic participation*
alienation	asylum seekers	economic participation
belonging	battered women	employment
community building	bullying	income
community development	conflict	inequality
community renewal	cultural diversity	inequity
cooperation	discrimination	poverty
participation	diversity	social determinants
social activities	domestic violence	social exclusion
social capital	freedom from discrimination	social gradient
social cohesion	Indigenous health	social participation
social exclusion	inequality	socioeconomic status
social integration	intimate partner violence	
social isolation	minority stress	
social networks	partner abuse	
social position	personal autonomy	
social relations	physical security	
social support	prejudice	
social ties	racism	
supportive environments	self determination	
supportive relationships	self-harm	
trust	sexual, physical, emotional abuse	
urban regeneration	social alienation	
	spouse abuse	
	stigma	
	victimisation	
	violence	

In addition, the above search terms were combined with searches on the following *mental health outcomes*: stress, anxiety, depression, common mental disorders, wellbeing, emotional well-being, and mental health.

Report structure

This report is divided into three parts:

- Introduction and overview of the report structure;
- Summaries of the literature on specific determinants of mental health; and
- Tables containing details of the literature collected.

Summaries

This part of the report contains concise summaries of the literature examined for each of the following determinants of mental health: A) Social Capital; B) Social Networks; C) Socio-economic Status and Inequality; D) Discrimination; E) Collective Trauma and Violence; and F) Interpersonal Victimisation.

In the summaries, the information is classified into four categories:

1. Concept definition e.g. definition of the term 'social capital';
2. Evidence of correlations and associations between each determinant and mental health;
3. Options for policy and practice intervention to address the determinant e.g. identified from discussion papers, planning documents or case studies; and
4. Evidence of the effectiveness of interventions from research and evaluation studies.

Each summary concludes with a section suggesting the implications of the literature for consideration by VicHealth. The references from the summaries are described in more detail in the tables provided in the third part of this report.

Tables

The tables classifying the literature that we appraised have been labelled to correspond with the social determinants A) to F) above and the four categories of information (concept definition; evidence of associations with mental health; intervention options; and evaluations of interventions). Some tables are further subdivided. For example, information about the association between social capital and mental health is divided into that derived from 'empirical studies' and that from 'overviews and summaries'.

Many papers contribute more than one category of evidence e.g. a paper may examine the problems of defining social capital and also present information about the association between social capital and mental health. Where this occurs, the relevant information has been extracted from the literature and presented in separate tables. (As a result, individual references can appear in more than one table.)

SUMMARY A – SOCIAL CAPITAL

Summary of project decisions pertaining to Social Capital

During the development and conduct of this review, the following decisions were made regarding the scope of the literature to be examined on 'Social Capital'.

- The 1999-2002 VicHealth Mental Health Promotion Framework refers to the concept of 'social connectedness', which was identified as encompassing 'supportive relationships and environments', 'social and physical activities', 'social networks', and 'valued social position'. An objective of this review was to examine the literature on the relationship between social connectedness and mental health.

- A preliminary overview of the literature that identified recent trends to distinguish between the following studies on social connectedness:
  - Studies of egocentric or individual-level measures of social connectedness, such as the number and nature of social networks and social ties (Berkman and Glass, 2000).
  - Studies of social connectedness as a collective or ecological (group-level) concept, using, for example, measures of social cohesion and social capital (Kawachi and Berkman, 2000).

- It was agreed that the project team would adopt this distinction and prepare separate summaries of the literature on (A) 'Social Capital' and (B) 'Social Networks'.

- The literature on social capital is relatively new, often complex, and continues to evolve. It was thus determined that there was a need to examine and report in detail all four categories of information available in the literature i.e.:
  1) Concept definition i.e. definition of the term 'social capital.'
  2) Evidence of correlations and associations between social capital and mental health.
  3) Options for policy and practice interventions to address social capital.
  4) Evidence of the effectiveness of social capital interventions from evaluation studies.

The four categories of information pertaining to social capital are summarised below.

1 Concept definition

Details of the references discussed below are given in the following table:

Table A.1: Social capital – definitions and models.

Summary

- Social capital has received much attention in recent health literature. Definitions of social capital are various and continue to be adapted and revised by interested parties. Two recent definitions include: *"the resources available to individuals and to society through social relationships"* (Kawachi et al, 2002); and *'networks, together with shared norms, values and understandings which facilitate*

cooperation within or among groups' (Adopted by ABS, 2002 - from Organisation for Economic Co-operation and Development, OECD, 2001).

- A distinction between the following types of social capital is widely adopted:
  - *Bonding* (relations and strong bonds among family members, close friends and neighbours, people like ourselves);
  - *Bridging* (weaker ties among distant friends, acquaintances, associates, colleagues, 'social oil', a horizontal concept of links with people different to ourselves); and
  - *Linking* (connections between institutions and members of community, or between groups with different levels of power or social status, a vertical concept (Putnam, 2000; Woolcock, 2001).

- An important consideration in defining social capital is the distinction between what it *is* (e.g. networks and norms) and what it *does* (e.g. to generate trust) (Woolcock, 2001; Putnam, 2001). One may also distinguish between the *sources* and *consequences* of social capital. Other considerations have been to distinguish between the *structural* components (e.g. extent and intensity of links or activities) and the *cognitive* components (e.g. perceptions of support, reciprocity or trust) of social capital (Harpham et al, 2002). These distinctions, however, are not universal, and many prevailing definitions of social capital combine structure and function (Kawachi & Berkman, 2000).

- Given the complexity of what may be encompassed in the term social capital, it is important that research and intervention initiatives disaggregate its dimensions and identify their underpinning theory and rationale (Hawe and Shiell, 2000; Campbell et al, 1999). For example, how is social capital defined; what dimensions are to be examined; and the purported mechanisms or causal pathways that are to be examined between aspects of social capital and mental health outcomes.

Strengths, limitations, and critique

- A key aspect of the recent public health literature on social capital is the emphasis on its capacity to reflect the *collective* or *ecological* dimension of society. Social capital could thus be considered external to the individuals in a society and thus distinguished from those measures that are hypothesised to have an effect at the level of the individual e.g. social ties or social support (Kawachi & Berkman, 2000; Lochner, Kawachi & Kennedy, 1999).

- The distinction of social capital as a neighbourhood / contextual variable is not however universally adopted. For example, Aldridge et al (2002) discuss the relationship between social capital and key policy outcomes on individual, as well as community and national levels; while Berry & Rickwood (2000) and Pevalin & Rose (2002) specifically focus on individual-level measures of social capital.

- Most community-level measures of social capital are derived by aggregating individual responses to survey questions, i.e. neighbourhood means of individual measures (Lochner et al, 1999; McKenzie et al, 2002). A recent study proposed that these aggregated community measures of social capital actually represent artefacts of community composition rather than truly ecological constructs (Subramanian et al, 2002).

- Many of the available reviews identify the ongoing challenge of adequately defining and measuring social capital as an ecological variable (Hawe & Shiell, 2000; Harpham et al, 2002). A few recent studies have sought to incorporate more contextual measures of social capital (Ostir et al, 2003; Lindstrom et al, 2003). To date however, few truly collective, contextual or ecological measures of social capital have been developed and used in health research (e.g. observational data on the nature of the environment and the activities, structures, and functions of community networks).

- The strongest analytical results on the nature and affects of social capital come from micro-level studies (local community). Yet the networks and associations constituting social capital are both local and non-local in nature (Campbell et al, 1999). Social capital also operates at meso-and macro levels of society (e.g. along vertical associations and hierarchies, and in the broader social and political environment and structures) (Cullen & Whiteford, 2001).

- Horizontal interactions between individuals are likely to be determined in part by policies and interventions of local and national governments, and the power relations and opportunities in society, i.e. vertical aspects of social capital (McKenzie et al, 2002; Harpham et al, 2002). Indeed, McKenzie hypothesises that high-bonding horizontal social capital (i.e. close ties within select communities) that occurs at the expense of vertical integration into societal structures may become pathological.

- The social capital that is identified in a community will be created, sustained, and accessed in different ways by subgroups and individuals. For example Campbell et al (1999) found strong differences by age, gender and ethnicity. They also proposed that some dimensions of social capital are more health enhancing than others, and this is likely to vary by community and setting.

- There is overlap in the literatures on social capital (and its association with health and mental health) and the social determinants of health or inequalities in health (Kawachi et al, 2002; Veenstra, 2001; Kawachi & Berkman, 2000; Lynch et al, 2000). The literature on *socioeconomic status* and *inequality* and mental health are examined in Summary C of this report.

- There is also some overlap between the concept of social capital and *civil society,* which has been defined as *"a sphere of social interaction between economy and State, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication"*[1].

- Civil society has also been identified as a core ingredient and essential context for successful community-based interventions (i.e. the 'setting of settings') (McLeroy, 2003). However, examining the relationship between social capital and civil society - and the implications for mental health promotion - was not within the scope of this project.

[1] Cohen & Arato (1994) quoted in: Jareg P & Kaseje DCO. Growth of civil society in developing countries: implications for health. *Lancet* 1998; 351: 819-822.

2 Key findings and conclusions on the link between social capital & mental health

Details of the references discussed below are given in the following tables:

Table A.2.1: Social capital – Association with mental health – summaries and overviews of evidence; and
Table A.2.2: Social capital – Association with mental health – empirical studies.

Summary

- Much of the available literature has focused on the association between social capital and physical health, but empirical studies of social capital and mental health are growing in number (McKenzie, 2002).

- There is growing evidence of correlations between various dimensions of social capital and aspects of mental health such as: common mental illnesses (Pevalin, 2002; Pevalin & Rose, 2002); happiness and wellbeing (Saguaro Seminar, 2001; Putnam, 2001); self-assessed mental health status (Baum et al, 2000); depressive symptoms (Ostir et al, 2003); feelings of insecurity related to crime (Lindstrom et al, 2003); general psychological distress (Berry & Rickwood, 2000; Berry & Rogers, 2003); emotional health (Rose, 2000); binge drinking (Weitzman & Kawachi, 2000); and, indirectly via positive parenting and neighbourhood danger, child psychological adjustment (Shannon & Rex, 2003).

- There is also established evidence of an association between social controls (which can be interpreted as an aspect of social capital), suicide, and anti-social behaviour like violent crime (Cullen & Whiteford, 2001).

- There is also good evidence on the clustering of problems in communities, such as *social pathologies* (substance abuse, violence, abuse of women and children), *exacerbating conditions* (unemployment, poverty, limited education, stressful work conditions, discrimination), and *health problems* (physical and mental). The fundamental causes of this clustering have been linked to resources like money, power, prestige and social connections (Cullen & Whiteford, 2001 - quoting Desjarlais et al, 1995).

- The Social Capital and Mental Health Workshop convened by the World Bank in Washington DC in July 2000 considered the status of current knowledge on the relationship between social capital and mental illness. The Workshop reached the following conclusions (Cullen & Whiteford, 2001, p23):

  - *the mechanisms that forge interaction are not unidirectional;*
  - *causality and reverse causality need further examination;*
  - *there are immediate effects – especially for the young;*
  - *studies examining these interrelations should consider the long-term socio-economic and socio-cultural effects, and thus be longitudinal;*
  - *the effects of vulnerability can be long term; and*
  - *precipitants and perpetuators can be short term.*

Strengths, limitations, and critique

- As noted in the Concept Definition, most available studies on the sociology of mental health have examined aggregates of individual measures, i.e. surveys of individuals' social ties and social participation, rather than truly collective

measures (Schwartz, 2002). Although it was thought that the concept of social capital would provide a way of addressing this limitation (Cullen & Whiteford, 2001), difficulties in measuring ecological aspects of social capital remain a key limitation of the evidence on the relationship between social capital and mental health (McKenzie et al, 2002).

- Although there are positive correlations between social capital and mental outcomes, there are also indications that social capital (measured at an individual level e.g. participation in organisations, contact with friends, perceptions of crime and levels of attachment to the neighbourhood) does not mediate the negative effects on health of basic social and economic structural factors (Pevalin & Rose, 2002).

- It has also been proposed that the impact of social capital on health may be experienced differently by different sub-groups in a community, and that this will vary by time and place (Campbell et al, 1999; McKenzie et al, 2002). Studies also indicate that while cohesive societies may protect against depression, the oppressive and controlling nature of some of these communities is also associated with greater anxiety (Kawachi & Berkman, 2001).

- Explanations have been proposed for the mechanisms by which social capital may impact on health (Kawachi & Berkman, 2000); and theoretical distinctions have been made between *contextual* and *compositional* effects (Kawachi & Berkman, 2000; Veenstra, 2001). Explanations also draw on existing literature about socioeconomic inequalities and health, and include complementary hypotheses that emphasise either the *psychosocial* or *material* benefits which may be derived from social capital (Hawe & Shiell, 2000).

- Empirical evidence is limited to support the alternative explanatory hypotheses of the relationship between social capital and mental health and health. Even recent studies are cross-sectional (e.g. Ostir et al, 2003; Lindstrom et al, 2003; Berry & Rogers, 2003), and the veracity of a causal relationship between social capital and mental health has not yet been empirically tested (McKenzie et al, 2002).

- The 2000 Social Capital and Mental Health Workshop formulated six recommendations on aspects of the relationship between social capital and mental health that require further research (Cullen & Whiteford, 2001, p34):

  1) *Examine the interrelations of human capital and social capital, exploring the distinctions, dynamics, and relationships between the two.*
  2) *Sharpen the tools for measuring social capital, especially in relation to those social capital variables most pertinent to health and mental health analysis and research.*
  3) *Elaborate the links between health, mental health, and social capital by undertaking prospective longitudinal studies in both developed and developing countries.*
  4) *Analyse the links between mental health, violent conflict and social capital, by for instance examining the ways social capital may be able to enhance mental health interventions and service delivery and mental health status through the networks, support and norms social capital provides.*
  5) *Examine how improvements in individual and population health and mental health might build social capital, and quantify the economic benefits of this.*
  6) *Examine how social policy, including health policy, can be developed so as to promote the growth of social capital and mitigate against its erosion.*

3 Suggested policy and intervention options

Details of the references discussed below are given in the following tables:

Table A.3.1: Social Capital - Intervention – options; and
Table A.3.2: Social Capital - Intervention > Mental health- options.

Summary

- There is broad interest in enhancing social capital as a potential policy and practice agenda - both within and beyond the health sector. Government discussion papers on social capital (implications for policy and practice) have been prepared for the Australian Bureau of Statistics (ABS, 2002); the UK cabinet office (Aldridge, 2002); and the Australian National Mental Health Strategy (Cullen & Whiteford, 2001)

- Intervention options, and their potential effects, can be classified into two groups:
  (a) those seeking to build social capital for its intrinsic worth or associated social benefits; and
  (b) interventions that harness social capital specifically as a means of promoting positive mental health and wellbeing. (Note: there is more literature on the former than the latter).

- Due to the relative novelty of social capital, the intervention literature tends to come in the form of theoretical models, recommendations, policies, case studies, and some process evaluations (described here) rather than evidence of intervention effectiveness (fourth category of evidence).

- The Saguaro Seminar's 'Better Together' report (2002) is a comprehensive source of case-studies and policy options to enhance social capital and reinvigorate civic life. Chaired by Robert Putnam, this US based group has outlined detailed recommendations for initiatives in the workplace; arts; politics and government; religion; schools; youth organisations; and families. (Translation required for Australian context – see 'implications' below)

- The Australian National Mental Health Strategy discussion paper (Cullen & Whiteford, 2001 p13) strategies for building social capital: strengthening social networks, community organisations, community ties, and civil society.

- The 'Riverdale community quality of life model' identifies key elements (supports and barriers on micro, meso and macro-levels) that are perceived by key members from the local community to contribute to quality of life and wellbeing. These included the following aspects: Federal and provincial social policy; municipal support of community infrastructure; responsive community institutions; citizen coalitions and groups; and characteristics of community members (this includes measures related to social capital such as neighbourliness, political orientation and sophistication, support of local institutions). The model was developed from qualitative research conducted in Toronto, Canada (Raphael et al, 2001).

Some project examples

- The *CommunityLIFE* website lists projects funded under the National Suicide Prevention Strategy. Many of these projects adopt strategies that address aspects of social capital.

- The University of Queensland Community Service & Research Centre has a web page on social capital. It includes reports on the Centre's Goodna Service Integration Project' (2000 – 2003) that was designed to 'build social capital' and facilitate integration of services provided by local government agencies.

- The Association for Services & Trauma Survivors implemented a project in Perth, WA, with the aim of building social capital in a new refugee community. Difficulties faced by the project team and the progress achieved on particular goals (e.g. establishing a community centre and radio program) are described in a case study, but there is no reported evaluation of social capital (Tomlinson & Lee, 2001).

Strengths, limitations, and critique

- An Australian study (Fattore, 2003) cautioned against simplistic notions that 'more community' is good when promoting social capital. The study distinguished between different forms of trust (personal trust in friends and neighbours; general trust in others; and trust in government). It showed that different types of trust have different predicting variables, and if damaged, have different consequences and require different remedies.

- A UK study based on the British Household Panel Survey (Pevalin & Rose, 2002) cautioned that developing individual social capital may produce some benefits for health, but will do little to negate more fundamental inequities in health that occur as a result of structural factors like income, employment, and education.

- African-Caribbean residents in a deprived area in the UK identified their lack of community unity as a disadvantage that increased their social exclusion and limited their access to resources. A second study revealed severe obstacles to implementing principles of community participation in local initiatives to improve mental health: distrust between sectors, disillusionment of lay people, lack of community capacity, and inadequate resources (Campbell & McLean, 2002).

- As social capital interventions emphasise the collective, ecological notion of community, program planning can benefit from considering the typology of McLeroy et al, (2003), in which community-based interventions are classified as: 1) the setting for intervention; 2) target of change; 3) a resource for intervention; and 4) as the agent of change. The authors also distinguish between the *level* at which one intervenes and *target* of intervention i.e. intervention may occur at one level and produce change at others.

4 Implemented interventions and evaluations

Details of the references discussed below are given in the following table:

Table A.4: Social Capital - Intervention - evaluations of effectiveness & systematic reviews.

Summary

- We identified no rigorous evaluations of projects explicitly designed to build 'social capital' as a strategy to improve mental health or wellbeing.

- There is significant overlap however, between the concept of social capital and other policy and practice initiatives that focus on, for example, urban or community 'regeneration', 'community development', 'community renewal' and 'community building'. Such projects employ strategies that harness aspects of existing social capital, and may potentially build or strengthen social capital.

- The majority of such projects are initiated and implemented outside the health sector and target multiple locally-identified problems and issues in a geographical or administrative area. Examples are the appearance and safety of the environment, housing, childcare, policing, job creation, transport, recreation facilities, etc. Evaluations of such initiatives are also likely to focus on achieving improvements in these concrete outcomes, e.g. graffiti or crime rates. Although the link is not always made explicit in these projects, such measures could be conceived as community-level measures of social capital.

- The UK Beacon project is a particularly well documented case study of community regeneration. It relied on the prevailing government policies and grants, but reported impressive results including reduced crime rates, depression, reduced child protection orders, increased educational attainment, and reduced teenage pregnancy rates (cited in Duggan (2002) and described in various on-line sources).

- Sydney's outer suburb Claymore has also been widely reported as a successful example of community-led urban regeneration. (For example, see http://www.accord.org.au/social/profiles/claymore.html; an ABC Compass video described initiatives in Claymore http://www.abc.net.au/programsales/programs/s735677.htm; the Claymore community has also been briefly described as a case study in Ann Deveson's *Resilience*. Allen & Unwin, 2003).

- The NSW Government 'Community Builders' initiative is a State-wide program of community development projects that incorporate aspects of social capital (http://www.communitybuilders.nsw.gov.au/).

Some implications for consideration by VicHealth

- Some innovative and exciting policy and program options have been identified from the USA and the UK specifically for building or harnessing social capital. These initiatives are however, determined by the social and political context in which they were developed, and significant attention would need to be given to whether (and how) they can be adapted for Australia. This translation and/or development role may be considered by VicHealth.

- Interventions seeking to enhance or harness social capital should take account of the literature demonstrating that neighbourhoods and regions with socio-economic deprivation and inequalities are associated with low social cohesion and social capital.

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SUMMARY B – SOCIAL NETWORKS

Summary of project decisions pertaining to Social Networks

The following decisions were made regarding the scope of the literature to be examined on 'social networks'.

- As described earlier, the 'social connectedness' literature can be divided into studies of 'social capital' (Summary A) and studies of 'social networks'. The latter comprises studies of egocentric or individual-level measures of social connectedness, such as the number and nature of social networks and social ties, and access to social support (Berkman and Glass, 2000).

- Concepts such as social networks, social ties, and social support are well established in the mental health field. The literature on the associations between social networks and mental health is large and has been reviewed in detail. Some reviews have also been conducted of literature on interventions targeting social networks and social ties with the aim of improving mental health.

- It was determined that this project will examine and summarise *existing literature reviews* (rather than individual empirical studies) and focus on two of the four categories of information i.e.:

    2) Evidence of correlations and associations between social networks and mental health.
    4) Evidence of the effectiveness of social network interventions from evaluation studies. [2]

2 Key findings and conclusions on the link between social networks and mental health

Details of the references discussed below are given in the following table:

Table B.2: Social networks – association with mental health (summaries of evidence).

Summary

- There is strong epidemiological evidence of significant and persistent correlations between poor social networks (weak social ties, social connectedness, social integration, social activity, and social embeddedness) and mortality from almost every cause of death (Berkman and Glass, 2000; Seeman, 2000).

- Research has consistently demonstrated that social networks and social ties have a beneficial effect on mental health outcomes, including stress reactions, psychological wellbeing, and symptoms of psychological distress including depression and anxiety (Kawachi & Berkman, 2001). However, critical and/or overly demanding social ties have been correlated with increased stress and risk of depression among the elderly (Seeman, 2000).

[2] The review of social networks literature did not focus on the other categories of information i.e.: *1) Concept definitions*; and *3) Options for policy and practice* derived from discussion papers, planning documents, and descriptive case-studies.

- Two different, but potentially complementary mechanisms have been proposed to explain how social networks influence mental health (Kawachi & Berkman, 2001):

  (a) *Main effect* model – where social networks have a beneficial effect on mental health regardless of whether or not individuals are under stress.

  (b) *Stress buffering* model – where social networks improve the wellbeing of those under stress by acting as a buffer or moderator of that stress.

- Studies have also identified the importance of adopting a 'life-course' perspective when considering the relationship between social networks and health e.g. social support during *key periods of development* have a *long-term* impact on psychosocial and physical wellbeing (Berkman and Glass, 2000).

- Until recently, much of the available research on social networks and health examined the effects of *social support.* It therefore gives a relatively narrow view of the benefits derived from social networks. Since the 1990s, however, researchers have identified other benefits of social networks, and examined the various mechanisms by which social networks impact on health.

- The body of empirical research on social networks and health has been summarised by Berkman and Glass (2000) in an integrated model that proposes how aspects of *mental health* (*psychosocial factors and psychological pathways*) act as intervening variables in the causal pathway between social networks and health. Thus, social networks act as a source of:

  (a) *social support*;
  (b) *social influence;*
  (c) *opportunity for social engagement* and thus *meaningful roles;*
  (d) *resources and material goods;* and
  (e) *intimate one-on-one contact* (which can impact on health via the transfer of infectious agents, as well as providing emotional support and companionship).

  The research also indicates that the (a) to (e) act along three complementary pathways:

  i. influencing health *behaviours;*
  ii. on *psychological pathways* by influencing *self-efficacy, self-esteem, coping effectiveness, depression, distress and sense of wellbeing;* and
  iii. directly impacting on physical health along physiologic pathways.

- It has been proposed that the *structural* aspects of social networks (e.g. level of social integration) are most likely to have a *direct* effect on mental health and wellbeing regardless of stressful circumstances; while the *functional* aspects (eg perceived support) are more likely to operate by *buffering* the effects of stress (Kawachi & Berkman, 2001).

- There has been a significant increase in mean levels of anxiety among US college students and school children. A large meta-analysis of routinely collected data from 1952–1993 correlated this rise in anxiety with reduced social connectedness and higher environmental threats (e.g. from crime), but not economic conditions (Twenge, 2000).

Strengths, limitations, and critique

- Published reviews identify the need for better understanding of the relationship between social networks (egocentric measures) and *social capital* (contextual measures). Kawachi and Berkman (2001) concluded that empirical investigations need to demonstrate the *contextual influence of social capital on individual networks and support and individual-level mental health outcomes*.

- The benefits and costs (e.g. anxiety associated with oppressive social ties) are not randomly distributed in the population, but rather systematically modified by gender, socioeconomic position and stage in life (Kawachi & Berkman, 2001). Future research and intervention programs need to take account of these potential sub-group effects.

4 Implemented interventions and evaluations (reviews)

Details of the references discussed below are given in the following table:

Table B.4: Social Networks – intervention evaluations (reviews).

Summary

- No reviews were identified of population-wide interventions that seek to promote mental health or prevent depression and anxiety by building social networks or enhancing existing social networks.

- Kawachi & Berman (2001) conclude that two decades of intervention research have demonstrated the feasibility of manipulating and enhancing social support, but that there is less evidence about the actual effectiveness of such interventions as a means of improving mental health.

- Existing reviews of social support interventions have tended to focus on programs targeting 'high risk' individuals (eg NHS Centre for Reviews and Dissemination, 1997). Such interventions tend to be delivered to small groups or one-on-one to 'at risk' individuals by health or social service professionals.[3]

- Social support interventions that have shown to be effective in existing reviews include:
  - parent training programs for improving maternal mental health (Barlow & Coren, 2002);
  - home-based social support for socially disadvantaged mothers (Hodnett & Roberts, 2001); and
  - caregiver support for postpartum depression (treatment rather than prevention) (Ray & Hodnett, 2001).

[3] Interventions aimed at promoting community-wide social ties are examined under *Social Capital* in Section A.

Strengths, limitations, and critique

- Significant variations in the design, duration, timing, and type of social support intervention studies that are available have resulted in few generalisable lessons that can be gleaned from the literature (Kawachi & Berkman, 2001).

- There is a need for empirical data to demonstrate that interventions that increase social support also improve mental health outcomes.

- Future evaluation research of social network interventions should provide empirical evidence of the following:
  - *mechanisms* by which social network interventions improve health outcomes;
  - *characteristics* of those who benefit most (and least) from social network interventions; and
  - nature of the 'dose-response' relationship between social networks and mental health (and whether there is a *gradient* of benefit or a *threshold* effect) (Kawachi & Berkman, 2001).

- Evaluation research also needs to compare interventions that strengthen existing networks with those that enhance and build new networks (Kawachi & Berkman, 2001).

Some implications for consideration by VicHealth

- There is strong evidence that poor social networks and ties are correlated with poor mental health outcomes. To date, effective social support interventions have been those provided by health or welfare professionals to disadvantaged and 'at risk' groups – particularly parenting programs.

- Broader social network interventions may improve and enhance social support, but it is unclear whether such interventions also improve mental health outcomes. Community-wide programs aimed at enhancing social networks and social cohesion at a population level should be informed by the literature on social capital (section A).

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SUMMARY C – SOCIO-ECONOMIC STATUS AND INEQUALITY

Summary of project decisions pertaining to socio-economic status and inequality

During the development and implementation of this review, the following decisions were made regarding the scope of the literature to be examined pertaining to socioeconomic status and inequality.

- The 1999-2002 VicHealth Mental Health Promotion Framework refers to the concept of 'economic participation' as one of three social determinants of mental health.

- In consultation with VicHealth it was determined that literature on 'economic participation' would be included in the scope of this review.

- It was also determined that the review would expand its scope beyond 'economic participation' to the broader concepts of *socio-economic status* (SES) and *inequalities*. The aim was to examine more widely the impact on mental health of social and economic determinants, and to draw on the growing literature on the aetiology of health inequalities.

- The literature on the health effects of SES and inequalities is quite large and there have been some excellent recent reviews of the literature. It was decided that this review would primarily draw on *existing reviews and summaries of the literature*, although a few of the recent empirical studies that examine relevant aspects of mental health have also been included.

- It was decided that this review would report on all four categories of information available in the literature:

  1) Concept definition e.g. definition of the terms 'SES' and 'inequalities.'
  2) Evidence of correlations and associations between SES and inequalities and mental health.
  3) Options for policy and practice interventions to address SES and inequalities.
  4) Evidence of the effectiveness of interventions addressing SES and inequalities from evaluation studies.

  The four categories of information on SES and inequalities are summarised below.

1 Concept definition

Details of the references discussed below are given in the following table:

Table C.1: SES and Inequality – concept definitions.
Refer also to other tables in section C.2.

Summary

- Socio-economic status is influenced by social and economic factors such as education, employment, income, race, and living circumstances. SES is often correlated with social class, which conveys the position or location of individuals in society according to their ownership or control of social, political and cultural resources and assets (Muntaner C et al, 2000).

- Inequalities refer to differences between groups in a population. Inequality and social stratification are also used to denote social hierarchy; e.g. the notion that social and economic resources are unequally or unevenly distributed within society along a socio-economic gradient (Muntaner C et al, 2000).

- Inequalities in socio-economic status are correlated with inequalities in health (Turrell and Mathers, 2002). The relationship between inequalities in SES and health can be explained in terms of resources that elevate or sustain health status i.e. purchasing power (income), knowledge power (education) and employment power (prestige and control) (Veenstra, 2001). Inequalities in health have been described as 'inequities' when they are 'avoidable, unnecessary, and unfair' (Dahlgren and Whitehead, cited in Raphael, 2000).

- Degrees of inequality vary significantly i.e. some societies are relatively egalitarian while others have extreme levels of wealth and poverty. One can compare populations, regions, or countries by the steepness of the socio-economic gradient. The degree of social and economic inequality within society has in itself been proposed as a determinant of health; i.e. highly unequal societies have poorer health status (reviewed in Veenstra, 2001).

- Degrees of socio-economic inequality have been found to be also inversely correlated with social cohesion. Social cohesion is the extent of social connectedness and solidarity among groups in society (Kawachi and Berkman, 2000). Thus, social cohesion refers to:
  - Absence of latent social conflict such as *income inequality*, *racial tensions*, *disparities in political participation* and other forms of *polarisation*.
  - Presence of strong social bonds, with high levels of social capital and civil society (e.g. high levels of trust and reciprocity and associations that bridge social divisions).

- There has been a shift in the conceptualisation of socio-economic factors from a dichotomous to a continuous variable. For example, employment status does not simply mean employed versus unemployed, but a continuum ranging from adequate employment (e.g. secure, appropriately paid, good job satisfaction) to inadequate employment, to unemployment (Dooley, Prause and Ham-Rowbottom, 2000).

2 Key findings and conclusions on the link between socio-economic status and inequalities with mental health

Details of the references discussed below are given in the following tables:

Table C.2.1: SES and Inequalities – association with mental health (reviews/summaries);
Table C.2.2: SES and Inequalities – association with mental health (empirical studies);
Table C.2.3: SES and Inequalities (children/youth) – association with mental health; and
Table C.2.4: SES and Inequalities – association with social capital.

Summary

- There is an established literature demonstrating strong correlations between social class (and other forms of socioeconomic stratification) and mental health – particularly psychiatric disorders such as schizophrenia and personality disorders, but also anxiety, depression and substance abuse (Bradley and Corwyn, 2002; Muntaner et al, 2000; Power et al, 2000; WHO, 2000; Henderson et al, 1998).

- Research has consistently found that mental health is relatively poor among those with low education levels, low-status occupations, and low incomes (Schwabe and Kodras, 2000; WHO, 2000; Astbury, 2001) and among unemployed people or those with job insecurity (Creed, Machin and Hicks, 1999; Power et al, 2000). Occupying a low social rank limits access to material and psychosocial resources, and affects individuals' ability to exercise autonomy and decision making over severe life events. Both of these have been consistently found to be associated with an increased risk of depression (WHO, 2000)

- A study on the effects of two types of adverse job changes (unemployment and inadequate employment) showed both were associated with increased depression. Those at increased risk of depression included women, the less educated, those with lower self-esteem, those with children, and those with less job satisfaction reported previously (Dooley, Prause and Ham-Rowbottom, 2000).

- The strong correlation between poor mental health and SES has also been demonstrated in children and adolescents (although less research is available on the latter). Children living in low SES households and disadvantaged neighbourhoods suffer more anxiety, depression, substance abuse and delinquent behaviour, and poor adaptive functioning. Children living in low SES circumstances are also more likely to be exposed to multiple adverse events and experiences (acute and chronic) which have a cumulative negative effect on their long-term mental health (Power et al, 2000; Bradley & Corwyn, 2002; McMunn et al, 2001).

- It is proposed that the mental health effects of lower SES in children is further compounded by broader social changes, e.g. increased proportion working mothers associated with less adult supervision and more time spent with peers; increases in school class sizes associated with decreases in teacher interaction and supervision; and growth of electronic media associated with children spending more time alone (Irwin, Burg and Cart, 2002)

- Links between class, race and psychological distress can, however, vary substantially by geography and gender (Black and Krishnakumar, 1998; Irwin, Burg and Cart, 2002; Schwabe and Kodras, 2000)

- Over the last two decades, there has been a surge in social epidemiology seeking to explain health inequalities. There has not been a parallel growth in research on inequalities in mental health (e.g. studies of psychiatric epidemiology or the sociology of mental disorders) (Muntaner et al, 2000).

- Some of the health inequalities literature however, contributes evidence on the social aetiology of mental health. Holistic assessments of health status often include measures of wellbeing and/or identify mental health outcomes (e.g. stress, anxiety, depression, behaviour problems, suicide) (Airey, 2003; Turrell and Mathers, 2002; Marmot and Wilkinson, 2001).

- The growing literatures on health inequalities, and on the relationship between inequality, social cohesion (including social capital) and health, have generated explanatory theories that incorporate aspects of mental health like stress, anxiety and depression. Some theories, including those about the health effects of collective ecological aspects of society, particularly emphasise the importance of psychosocial factors in explaining health inequalities (reviewed in Kawachi et al, 2002; Veenstra, 2001). Thus empirical data to support explanations of health inequalities often also contribute evidence on inequalities in mental health.

- There are three main theories regarding the relationship between social and economic inequalities and health: (i) psychological interpretation; (ii) 'risky behaviours' interpretation; and (iii) neo-materialist interpretation (summarised in Kawachi et al, 2002; Veenstra, 2001):

  - Psychosocial interpretation suggests those who have low SES *relative* to those around them suffer from a sense of relative deprivation, inferiority, anxiety, low self-esteem, embarrassment and shame. This may have physiological effects (Marmot and Wilkinson, 2001).

  - Risky behaviours interpretation suggests that stress and anxiety associated with low SES can result in a profile of risky behaviours that also impact on health (indirect effects).

  - Neo-materialist interpretations give more weight to material factors as the drivers of health inequalities i.e. food, shelter, access to services and amenities, car and home ownership, telephones, internet etc (Lynch and Smith et al, 2000).

- Although low levels of social capital have been correlated with poorer health, including mental health, a large UK study has found that social capital does *not* moderate or buffer the negative impact of structural socio-economic factors on health or common mental illness (Pevalin and Rose, 2002).

- Kawachi et al (2002) emphasise that psychosocial, behavioural and material explanations of health inequalities are not mutually exclusive; and that it is not always feasible or necessary to disentangle the effects in order to address the social determinants of health. For example, improved employment and income provide for basic needs *and* foster a sense of control and self-esteem.

- It has also been postulated that the large and growing socio-economic inequalities in the USA and the UK are associated with social processes and policies that systematically under-invest in social infrastructures and services. This under-investment affects on mental health and wellbeing in the following ways:

i) through direct subsequent effects on mental and physical health;
ii) by contributing to unequal societies that are divisive and result in further erosion of social cohesion and social capital; and
iii) through loss of social capital that in itself impacts on mental health and wellbeing.

However, the findings from the USA and the UK that greater inequality in society is associated with lower social capital have not been repeated in more 'equitable' societies such as Canada, suggesting there may be a threshold effect (literature reviewed in Kawachi et al, 2002; Veenstra, 2001; Lynch, Due et al, 2000).

Strengths, limitations and critique

- Most research on employment and mental health has focused on one type of employment change only, i.e. job loss (Dooley, Prause and Ham-Rowbottom, 2000).

- There is a need to disaggregate the concept of 'mental health disorders' to better understand relationships between variables (Schwabe and Kodras, 2000)

- Race, class and place are generally not independent factors; and identifying unique contributions of each is difficult (Schwabe and Kodras, 2000)

- Little research has examined the effects of gender in the interaction between race, class and place (WHO, 2000; Schwabe and Kodras, 2000)

- There is a need for more data about SES effects among adolescents with poor mental health (Irwin, Burg and Cart, 2002)

3 Suggested policy and intervention options

Details of the references discussed below are given in the following tables:

Table C.3.1: SES and Inequalities and mental health – intervention options;
Table C.3.2: SES and Inequalities - intervention options; and some sourced from; and
Table C.4.1: SES and Inequalities – intervention evaluations.

Summary

- There has been significant interest in policy and practice initiatives to address the growing inequalities in health in developed countries. The literature clearly indicates that interventions to improve health inequalities need to address social and economic inequalities, and improve the living and working conditions of disadvantaged groups (Wilkinson and Marmot, 1998; Raphael, 2000; Daniels, Kennedy and Kawachi, 2000; House, 2002; Mackenbach, 2003).

- Available reviews of existing interventions have noted that vulnerable families need to be supported by a coordinated system of supportive services that address multiple socio-economic factors (e.g. child care, housing and transport assistance, nutritional support, educational support, employment opportunities, health care, etc) (Anderson, Shinn and St Charles, 2002)

- There some recommendations in the literature specifically for mental health promotion; for example, Black and Krishnakumar (1998) provide 11

recommendations for interventions to promote well-being among urban low-income children.

- Last year, governments in the UK and the Netherlands released actions plans to address the inequalities in the health of their populations. These plans incorporate lessons from the available epidemiological literature on inequalities in health (Department of Health, 2003; Mackenbach and Stronks, 2002).

Strengths, limitations and critique

- Many intervention options identified to address inequalities in mental health focus on preventing the cycle of impoverishment and worsening mental health among those already diagnosed with mental illness (e.g. Henderson et al, 1998).[4]

- It seems, however, that social and economic interventions aimed at addressing health inequalities are highly relevant to the prevention of chronic stress and anxiety caused by deprivation, poor or insecure income, and poor working and living conditions (e.g. Wilkinson and Marmot, 1998).

- In relation to future evaluation research, Rogers at al (2001) propose recommendations for evaluating social policy and urban regeneration initiatives for their impact on mental health.

4 Implemented interventions and evaluations – socio-economic status

Details of the references discussed below are given in the following tables:

Table C.4.1: SES and Inequalities and mental health – intervention evaluations; and
Table C.4.2: SES and Inequalities – intervention evaluations.

Summary

- There have been numerous intervention programs in the USA targeting lower SES children and families. A systematic review of early childhood interventions recommends publicly funded centre-based comprehensive early childhood development programs for children aged 3-5 years at risk of poverty. These programs have been shown to improve cognitive and school outcomes, employment, home ownership, reduced teenage pregnancy, and lower arrests and incarcerations Anderson, Shinn and St Charles, 2002)

- A review of family housing interventions for lower SES families in the USA found that provision of tenant-based rental vouchers gives families the choice of leaving public housing estates in unsafe neighbourhoods and moving to private rental properties with reduced exposure to violence (Anderson, Shinn and St Charles, 2002).

- A review has been conduced of 345 intervention studies to improve the mental health of young people, especially those from socially disadvantaged groups. The vast majority of these studies were conducted in the USA and in educational settings. The review found conflicting evidence on effectiveness of mental health

[4] Note - these reports and policy documents have not been included in this review.

promotion programs. Studies on depression prevention showed that knowledge-based sessions of short duration were not effective. There was insufficient evidence to recommend school-based suicide prevention programs; self-esteem programs more likely to be effective when self-esteem is the main focus rather than part of a broader program. The content of mental health promotion interventions must be relevant to the context of young people's everyday lives (Harden et al, 2001)

- A systematic review of housing interventions in UK found that although studies show improvements in mental health after interventions, the quality of the studies has been generally poor. In disadvantaged areas where the local environment also requires significant improvements, a focus on houses alone is considered inappropriately reductionist and fragmentary (Thomson, Petticrew and Morrison, 2001)

- The UK government has introduced a major urban renewal program for disadvantaged areas. In Newcastle Upon Tyne the local 5.5 million pounds, five year housing renewal program (1992 – 1998) was used as an opportunity to research the health effects of poor housing and to evaluate the effectiveness of housing improvement. The intervention comprised environmental improvements, external repairs, refurbishment, demolition of void dwellings, renovation grants for individual dwellings, and improvements to security and road safety. Cross-sectional before and after data and longitudinal data were presented. Psychological distress showed significant decline (a fall of 10% in adults with one or more mental health problems in the cross sectional data, and a 50% reduction in adults having 'trouble with nerves' in the longitudinal data). The prevalence of smoking was halved in both cross sectional and longitudinal samples (Blackman et al, 2001).

- Past interventions for unemployed people have included counselling, training, case management, job clubs, drop-in centres, sporting opportunities, resume preparation, and free advertising in newspapers, but there have been very few effectiveness studies (Creed, Machin and Hicks, 1999)

Strengths, limitations and critique

- It seems unlikely that single interventions can protect disadvantaged children from 'harmful exposures'. Interventions most likely to be effective are those that are part of a coordinated program that addresses multiple social and economic determinants such as child care, housing, transport, nutrition support, employment opportunities and health care (Anderson, Shinn and St Charles, 2002).

Some implications for consideration by VicHealth

- The literature suggests that mental health promotion programs need to be comprehensive and address the socio-economic conditions that exacerbate poor mental health such as: low income; insecure employment, stressful work conditions or unemployment; poor quality housing; violent and run-down neighbourhoods; and social and political disenfranchisement.

- Those living in disadvantaged and disempowered communities are exposed to significant chronic stress and anxiety caused by their living and working

conditions. Such individuals and/or communities are less likely to benefit from psychosocial or behavioural mental health promotion interventions if they continue to be exposed to the material, structural and environmental factors that associated with poor mental health.

- There appears to be some evidence that marked social and economic inequalities are associated with poorer social cohesion and social capital and poorer mental health, over and above any direct effects of poverty and/or material deprivation. Mental health promotion interventions aimed at addressing social capital should take into account the potentially inhibiting or negating effects of significant socio-economic inequalities.

- Mental health promotion intervention must also address the clustering of mental health problems in communities with high rates of social pathologies, such as substance abuse, violence, and abuse of women and children (see Sections D to F).

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SUMMARY D - DISCRIMINATION

Summary of project decisions pertaining to discrimination

During the development and implementation of this review, the following decisions were made on the scope of the literature to be examined for discrimination.

- The 1999-2002 VicHealth Mental Health Promotion Framework includes the social determinant 'Freedom from Discrimination and Violence'. The concept *freedom from discrimination and violence* does not exist in the literature we reviewed. Rather, the adverse effects of discrimination and violence on mental health that have been studied empirically.

- Moreover, the concepts of discrimination and violence are complex, and published literature has increasingly given attention to studying constituent elements of both. For example, the relationship between discrimination and mental health has been studied with reference to different types of discrimination (e.g. due to gender, race, culture, or sexuality) and different types of mental health outcomes (e.g. depression, anxiety, drug and substance abuse, or suicide).

- In consultation with VicHealth, we replaced the determinant 'Freedom from Discrimination and Violence' with three determinants: discrimination (Summary D); collective trauma and violence (Summary E); and interpersonal victimisation (Summary F). While these terms share some common features, there are separate bodies of literature associated with each.

- It was also agreed that the literature on intervention options and evaluations for discrimination would be confined to discrimination due to race and discrimination due to socio-economic status (since they are closely linked).

- We found that interventions addressing discrimination (and prejudice) were not linked specifically to mental health outcomes. Rather, they focused on increasing knowledge and reducing biased attitudes and behaviour.

- We found no interventions specifically addressing discrimination due to socio-economic status (SES). Interventions associated with raising families out of poverty (e.g. through income supplementation) have been reported, and are included in Summary C - Socioeconomic status and inequality.

1 Concept definition

Details of the references discussed below are given in the following tables:

Table D.1.1: Discrimination (general) – definitions;
Table D.1.2: Discrimination (general) - conceptual and empirical issues;
Table D.1.3: Racial discrimination – definitions; and
Table D.1.4: Racial discrimination - conceptual and empirical issues.

Summary

Discrimination (general)

- Discrimination is defined as *"the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group … this unfair treatment arises from socially derived beliefs each group holds about the other, and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege"* (Oxford and Collins dictionaries of Sociology, cited by Krieger, 2001).

  According to this definition, random acts of unfair treatment do not constitute discrimination (Krieger, 2000).

- The most common forms of discrimination are racial or ethnic, gender, anti-homosexual, disability, age and social class. Religion has re-emerged as a basis for discrimination (Krieger 1999).

- The complexity of the concept of discrimination has only been recognised in recent years. For example, Krieger (2000) uses of six parameters to describe discrimination: form, type, agency, expression, domain, and level; AND four measures of exposure: timing, intensity, frequency, and duration.

Racial discrimination

- The term racism has been defined as *"… an organised system that leads to the subjugation of some human population groups relative to others … an ideology of inferiority … with some being inferior to others"* (Williams and Williams-Morris, 2000, p.244). *"Racism is not a problem to those who don't experience its effects, that is, the dominant group, yet it is often this group that sets the political and cultural agenda"* (Sanson et al, 1998, p.170).

- In the USA, residential segregation has been the key mechanism by which racial inequality has been created and reinforced, determining access to educational and employment opportunities, health care, and housing options (Williams, 1999).

- A new form of racism has emerged in the last two decades, referred to by some as 'aversive racism': *"… a subtle, often unintentional, form of bias that is characteristic of many ingroup members who possess strong egalitarian values and who believe that they are non-prejudiced, i.e. people who want to be fair and just, but who harbour negative feelings and behaviours"* (Dovidio et al, 2000, pp.5-6). It has been argued that this more modern racism is more insidious, entrenched, resilient and difficult to counteract (Sanson et al, 1998).

- Others have made distinctions between individual and institutional racism. For example, a paper examining racism and prejudice in Australia gives the following examples of institutionalised racism: under-representation of minority group members in the media, reinforcement of negative stereotypes in the reporting of conflicts involving minority groups, continuing restrictive immigration policies, limitations in access to education and employment for minority group members, and limitations in access to adequate standards of health, housing and basic infrastructure (Sanson et al, 1998).

- The relationship between racism and SES is complex. Racism has generally restricted SES attainment for members of all minority racial and ethnic groups. Race is an antecedent and determinant of SES and racial differences in SES reflect, in part, the successful implementation of discriminatory policies (Williams, 1999).

Strengths, limitations and critique

- Although recent research has recognised the complexity of the concept of discrimination, its definition and measurement have included some (but not all) of the parameters stated by Krieger (2000). In addition, considerable measurement difficulties are associated with discrimination. Empirically, it is usually measured by the victim's appraisal of the perpetrator's intention to discriminate in conjunction with unfair events (Brown, 2001).

- Much of the earlier research on discrimination did not consider these definitional complexities, so that the generalisability of results on general discrimination to specific forms and types of discrimination and mental health is difficult.

2. Key findings and conclusions on the link between discrimination and mental health

Details of the references discussed below are given in the following tables:

Table D.2.1: Discrimination (general) - associations with mental health;
Table D.2.2: Racial discrimination - associations with mental health;
Table D.2.3: Gender discrimination - associations with mental health; and
Table D.2.4: Gay/lesbian discrimination - associations with mental health.

Summary

Discrimination (general)

- Most of the literature on the association between discrimination and mental health examines specific forms of discrimination (e.g. due to race/ethnicity (Table D2.2), gender (Table D2.3), or homosexuality (Table D.2.4)). By far the largest body of evidence addresses racial discrimination, and it is almost exclusively from the USA.

- Krieger (2000) has identified three empirical approaches to assessing the health effects of discrimination, although all three methods have limitations:
  - *indirect*, by inference at the individual level (e.g. comparing the health outcomes of a subordinate group with a dominant group);

- *direct*, using measures of self-reported discrimination at the individual level; and
- in relation to *institutional discrimination* at the population level (e.g. policies of housing segregation).

- Research has consistently shown that higher levels of self-reported discrimination have been associated with poorer mental health (Krieger, 2000). A national survey in the USA (Kessler et al, 1999) found that over 60% of participants reported perceived day-to-day discrimination. Day-to-day discrimination appeared to be more strongly related to psychological distress than measures of 'lifetime major discrimination'.

- Importantly, a substantial proportion of people not considered to be socially disadvantaged thought of themselves as experiencing major discrimination at some time in their life. Kessler and colleagues (1999) suggest that it is the generic perception of unfairness, not the perceived reason for discrimination, which is adversely linked to mental health.

- Different types of discrimination appear to be associated with different adverse health consequences, e.g. women have higher rates of depression while gay people have higher rates of suicide and substance abuse (Krieger, 1999).

Racial discrimination

- Community- and population-level studies of discrimination have predominantly focused on racial discrimination among Black and Hispanic Americans in the USA (Krieger, 2000). Studies have shown associations between racial discrimination and sense of well-being, self-esteem, control or mastery, psychological distress, major depression, anxiety disorder, and other mental disorders (Brown et al, 2000; Kessler et al, 1999; Williams et al, 2003; Williams and Williams-Morris, 2000).

- Studies in the USA have also examined the interplay between racial discrimination, SES and various health outcomes, and found that SES differences within each racial group are larger than the racial differences across groups (Williams, 1999).

- Williams and Williams-Morris (2000) suggest that racism adversely affects mental health in at least three ways:
  - institutionalised racism can lead to restricted socioeconomic mobility, differential access to resources, lower SES and poor living conditions;
  - experiences of discrimination can induce physiological and psychological stress reactions; and
  - acceptance of negative cultural stereotypes of inferiority ('internalised racism') can lead to unfavourable self-evaluations that affect psychological well-being.

- Rollock and Gordon (2000) similarly acknowledge different effects of individual versus institutionalised racism on mental health. On an individual level, racism is associated with internal stress, general emotional well-being, and health and psychophysiology, and is linked with symptoms of psychological disorders. On a broader level, institutionalised racism affects the mental health functioning of both the dominant and subordinate social groups.

Gender discrimination

- Studies have consistently shown that women have higher rates of disability and illness, battery and sexual assault, depression, post traumatic stress disorder (PTSD), and suicide attempts compared with men. Men, on the other hand, have higher rates of alcohol abuse and completed suicides (Astbury, 2001). These gender differences reflect, in part, differences between women and men in the predisposition to some mental illnesses, and differences in social conditioning. However, women's increased risks of adverse mental health outcomes are also attributed to a wide range of significant adverse consequences disproportionately experienced by women: poverty, discrimination, violence, socio-economic disadvantage, low social status, and traditional female gender roles (Astbury, 2001; Patel et al, 1999). *"No society treats its women as well as its men"* (Astbury, 2001).

Gay/lesbian discrimination

- Studies of mental health problems among gay men and women indicate increased rates of substance misuse and depression, especially among gay men experiencing significant bereavement and loss arising from AIDS-related deaths among friends and community (Warick and Aggleton, 2002).

Strengths, limitations and critique

- Investigators have consistently called for more systematic investigations of the concepts of discrimination and mental health, including better (more objective) definitions. No consistent methods have been developed to measure self-reported discrimination, and all measures are inherently subjective (Brown, 2001; Brown et al, 2000; Krieger, 2000; Williams et al, 2003; Williams and Williams-Morris, 2000).

- There is also a need to acknowledge and better understand the interplay of more than one type of discrimination for some people (e.g. poor Moslem women, Black gay men, etc).

- Awareness is growing of the mediating effects of different individual vulnerabilities and coping strategies, and the need to better identify and assess them in studies of discrimination and mental health (Kessler et al, 1999; Warick and Aggleton, 2002; Williams and Williams-Morris, 2000).

3 Suggested policy and intervention options

Details of the references discussed below are given in the following tables:

Table D.3.1: Discrimination (general) - intervention options; and
Table D.3.2: Racial discrimination - intervention options.

Summary

Discrimination (general)

- The interventions we identified addressing prejudice and discrimination were not linked specifically to mental health outcomes. Rather, they focused on reducing biases in knowledge, attitudes, and behaviour.

- An excellent text, edited by Oskamp (2000), titled *Reducing Prejudice and Discrimination*, details various approaches to address discrimination at the individual and community levels.

- In the opening chapter, Oskamp notes that most studies associated with prejudice and discrimination have been directed at understanding the nature, causes and consequences of prejudice. Relatively little research has been directed at how to reduce prejudice and discrimination.

- Oskamp suggests that current approaches to addressing prejudice and discrimination can be grouped into three types:

  - *behavioural* includes intergroup contact under specified conditions, cooperative learning techniques, and structured intergroup experiences;
  - *cognitive* includes attempts to change stereotypes and attitudes; and
  - *motivational* includes reductions in feelings of threat from the outgroup, emphasising shared interdependence and accountability for intergroup events and outcomes.

- Oskamp states that laws and societal norms are the most powerful arena for changing patters of social interaction. There was a spate of such initiatives in the 1960s, spurred on by the civil rights movement in the USA. However, more recently, the most common approaches used to reduce prejudice and discrimination have targeted individuals and groups and been based on the 'contact hypothesis' (from Allport, 1954, cited by Oskamp, 2000). The contact hypothesis predicts a reduction in prejudice under the following four conditions:

  - equal status between the groups in the situation;
  - cooperative activity toward common goals;
  - personalised acquaintance (perception of common interests and common humanity); and
  - support for the contact by authorities or local norms.

  Approaches based on the contact hypothesis have received empirical support; one meta-analysis of 203 studies found a mean effect size of -0.42 (moderate effect) in reducing prejudice (Pettigrew and Tropp, 2000) (see Section 4 below for further details). In addition, this meta-analysis showed that reductions in prejudice with one outgroup could, in some cases, be generalised across social situations to other outgroups thus increasing tolerance and understanding to others.

- Johnson and Johnson (2000) argue that the school environment provides an optimal context in which to apply approaches based on the contact hypothesis. Schools often bring together children from diverse backgrounds who interact and work together, providing ample experiences and opportunities for developing personal relationships between ingroup and outgroup members.

  Johnson and Johnson's program for schools, called the Three Cs, focuses on establishing a cooperative community, resolving conflicts constructively, and internalising civic values. The design of the program draws on the results of a meta-analysis of 180 studies, which showed that cooperative experiences usually promote greater interpersonal attraction than do competitive or individualistic experiences.

- Stephan and Stephan (2000) have focused more specifically on fear and threat as the basis for prejudice and discrimination. They propose four types of threat:
  - realistic threats posed by the outgroup to the ingroup;
  - symbolic threats involving perceived group differences in morals, values, standards, beliefs and attitudes, which threaten the worldview of the ingroup;
  - intergroup anxiety, where people feel personally threatened in intergroup interactions; and
  - negative stereotypes giving rise to negative, conflictual or unpleasant expectations about the behaviour of the stereotyped group.

  Stephan and Stephan suggest that one approach to overcoming feelings of threat is *cognitive*, and relies on the premise that ignorance causes prejudice. If so, it may be possible to change real and symbolic threats with information, e.g. through multicultural education or cultural diversity training. On the other hand, interaction-based programs (such as cooperative learning techniques and intergroup dialogue programs) are more likely to be effective in reducing intergroup anxiety and negative stereotypes by providing people with social skills that facilitate intergroup interaction, and personal experiences that challenge stereotypes.

- Another model for reducing prejudice is offered by Major and colleagues (2000), who distinguish between three types of intervention:
  - efforts aimed at reducing or destroying the prejudicial attitudes, beliefs or behaviours of others (*prejudice destruction*);
  - efforts aimed at reducing the likelihood that outgroup members will be treated in a prejudicial way in a particular situation (*prejudice deterrence*); and
  - emotion-focused coping strategies aimed at diminishing the emotional impact of prejudice on outgroup members (*prejudice deflection*).

  Major and colleagues argue that there are differential costs and benefits associated with each type of intervention. For example, the benefits are potentially high from interventions seeking to destroy prejudice but the costs are also high since they require significant levels of effort, often prolonged over time. Prejudice deterrent strategies are likely to involve less cost and less benefit, since they usually do not challenge attitudes, values and beliefs of the perceiver but rather develop skills and techniques for use by the receiver.

Racial discrimination

- In 2003, the Scottish Government launched a £1 million advertising campaign, conducted over 5 weeks, aimed at tackling racism in Scotland. The campaign used television, cinema, radio and billboard advertising to increase awareness of racist attitudes and behaviour and to highlight the negative impact racism has on individuals and communities. The media campaign followed legislative changes introduced in 2000, which placed a general duty on government and other public bodies to promote racial equality (www.scotland.gov.uk/pages/news/2002/09/p_SESJ058.aspx).

- Rollock and Gordon (2000) provide a summary of various strategies that have been used to address racism with the specific aim of improving health outcomes, including mental health. Elements common to mental health interventions include raising of consciousness and clearing of cognitive distortions, recognising diverse contexts of oppression, affirming self- and group-identity, increasing self-mastery and autonomous dignity, and working towards self- and social improvements.

The authors also note that racism needs to be considered within the context of other 'isms' such as sexism and heterosexism.

Strengths, limitations and critique

- The intervention options proposed to address general discrimination and prejudice, and racial discrimination specifically, share many common elements. There appears to be a general consensus that interventions at the societal level are likely to be more effective, but also more costly. The recent national anti-racism campaign in Scotland is an example of this type. However, most intervention options described in the literature appear to be designed for implementation with individuals. Considerable support exists for approaches based on the 'contact hypothesis'.

- A fundamental question mental health professionals must answer in dealing with racism is whether racism should be addressed on the individual or the institutional level (Rollock and Gordon, 2000).

4 Implemented interventions and evaluations

Details of the references discussed below are given in the following tables:

Table D.4.1: Discrimination (general) – evaluations of interventions; and
Table D.4.2: Racial discrimination – evaluations of interventions.

Summary

Discrimination (general)

- Pettigrew and Tropp (2000) conducted a review of prejudice reduction programs based on intergroup contact (i.e. the contact hypothesis). A meta-analysis was performed of 203 individual studies (73% conducted in the USA), combining 90,000 subjects from 25 different nations. Of the 203 studies, 94% found an inverse relationship between contact and prejudice. Most research also demonstrated generalisation of the effects from the immediate participants in the contract programs to the entire outgroup; some studies even showed generalisation to other outgroups not involved in the contact program.

  Predictors of the size of the contact-prejudice effects included:

  - whether the participants were from a majority or stigmatised minority group: majority participants tended to show much larger mean effects than did minority participants; and
  - the specific outgroup to which participants belonged: for example, contact with homosexuals seemed to produce larger effects than contact with disabled people.

- Pettigrew and Tropp (2000) concluded that 'optimal intergroup contact' should be a critical component of any successful effort to reduce prejudice. They identified six issues relevant to achieving optimal contact:

  - programs to reduce prejudice should incorporate the four situational elements recommended by Allport (see Section 3 of this summary) and foster cross-group friendship;

- the perspectives of both ingroup and outgroup members must be considered when designing optimally structured contact situations;
- optimal intergroup contact has the potential, and should be designed in such a way, to seek to improve several components of prejudice, i.e. affect beliefs, social distance and stereotypes;
- contact in work and organisational settings has far stronger effects than those typical of travel and tourism settings; and
- it is important to actively create situations that counter prevailing negative stereotypes.

Further, Pettigrew and Tropp argue that social-structural changes in institutional settings are necessary to provide opportunities for optimal intergroup contact on a scale sweeping enough to make a societal difference; however powerful majorities typically resist such changes.

- Aboud and Levey (2000) reviewed five types of intervention programs that have been used with school children to reduce discrimination and prejudice:
  - *racially integrated schooling*: research indicates a greater impact on attitudes and relationships if this intervention is combined with at least one other type of intervention, e.g. cooperative learning;
  - *bilingual education*: research shows better outcomes if this type of schooling (focused on language and culture) is supported by contact with outgroup peers;
  - *multicultural and anti-racist education* designed to give students knowledge and attitudes to understand, respect and interact as equals with members of different ethnic groups: little evaluation exists of outcomes of these types of programs, but it appears that such initiatives need to include information that challenges stereotypes, and discussions of race and racism (appropriate to the age level of the children);
  - *training in social-cognitive skills*, i.e. teaching children new ways of processing information to alter schemas and age-related cognitive structures such as categorisation, that often distort the way children process multicultural information: there is some evidence of short-term success but no long-term follow-up; and
  - *role-playing and empathy*: the development of skills and capabilities to better appreciate the perspectives of ingroup and outgroup members: these approaches have some empirical support and can be of benefit for all forms of interpersonal and intergroup relations, but programs for large numbers of students are lacking, and they tend to require special training for teachers.

- The review also found that integrated and bilingual schooling have had some short- and long-term successes, especially in forming positive relations with cross-ethnic peers, although contact has not always reduced prejudice. The major strength of multicultural and anti-racist approaches is their ease of application even in relatively homogenous schools, but less empirical support exists for reducing prejudice and discrimination by these methods (Aboud and Levey, 2000).

Racial discrimination

- We identified one study evaluating a program that aimed to reduce prejudice towards Aboriginal Australians, conducted by Hill and Augoustinos (2001). The authors note that little evidence exists of formal evaluations of prejudice reduction

programs, and designing such evaluations is difficult; such programs typically use a variety of methods, and assessing whether, or what, is effective is problematic.

- Existing evaluations have also only examined short-term outcomes (usually immediately after delivery of the intervention). Hill and Augoustinos summarise the evaluations of three programs:
  - Cultural Awareness Program in the USA – an undergraduate program to increase awareness about racism on campus and in society. The evaluation results showed students were not significantly more positive towards people of other ethnic backgrounds and did not report more positive social interactions with them. However, participation in the program was voluntary and the attrition rate was high.
  - Shared Learning Program in UK – a program to increase interprofessional cooperation between doctors and social workers (based on the contact hypothesis). The results showed significant improvements in intergroup attitudes.
  - Police-Schools Liaison Program in UK – a program to improve students' attitudes to and perceptions of police by placing an officer in the school on a full-time basis. The results showed that students did not perceive the officer as a 'typical policeman' and rated the officer as more caring than police in general, thus the positive effects did not generalise to the intergroup context.

- Hill and Augoustinos developed a program aimed at increasing people's knowledge of Aboriginal Australian's history and culture, and reducing prejudice towards Aboriginal peoples. The program targeted employees of a large public health organisation in South Australia, and was led by Aboriginal employees who had volunteered as group facilitators. It was intended that these fellow workers would be accepted as peers while at the same time being members of the target outgroup. The program combined intergroup contact and information sharing, and was intended to challenge participants' negative stereotypes about Aboriginal peoples.

  A total of 62 participants attended six workshops. Only 31 participants (50%) responded to a follow-up survey three months after the program was completed. Results immediately after the program showed several positive effects: increased knowledge, reduced racism scores, decreased negative stereotyping and increased positive stereotyping. However, results at the three-month follow-up were much less encouraging: knowledge had declined although still higher than baseline, but racism scores, and negative and positive stereotyping had returned to baseline levels. The authors concluded that the program had short term effects but most were not sustained over three months.

- Hill and Augoustinos concluded that *"… the effectiveness of such prejudice reduction programs must be seriously questioned given their excessive focus on locating prejudice and racism within the psychological and cognitive domain of the individual, rather than, or in addition to, the oppressive structural arrangements and power relations within society"* (p. 260).

Strengths, limitations and critique

- The interventions that have been evaluated to tackle discrimination and prejudice have been exclusively focused on the knowledge, attitudes and behaviours of individuals.

- There have been other interventions in the past to address discrimination, which have not been evaluated systematically but which nonetheless are known to have had significant benefits. For example, Williams (1999, 2000) has described the significant impact of legislative changes in the USA during the 1960s that led to clear reductions in some types of racial discrimination towards Black Americans in the USA. Similar commentaries have appeared in Australia following the 1967 referendum that granted Aboriginal Australians voting rights. However, aside from the recent initiative in Scotland, there is little published evidence of the use of legislation as a major vehicle for further improving discriminatory practices.

Some implications for consideration by VicHealth

- There appear to be considerable opportunities for VicHealth to advocate for legislative and societal changes to reduce discrimination in Australia. The recent government campaign in Scotland provides a useful example of a contemporary intervention that has been implemented. It would be worthwhile to monitor its developments and any evaluation results that may emerge from it.

- With regards to interventions to address discrimination, an excellent text edited by Oskamp (2000), titled *Reducing Prejudice and Discrimination*, provides a succinct overview of approaches at the individual and community level.

- The majority of empirical evidence on discrimination derives from work in the USA, and predominantly with racial discrimination against Black Americans. This work has shown that, in the USA< race is the antecedent and determinant of SES differences. This probably explains, at least in part, why empirical studies have focused on racial discrimination rather than SES discrimination.

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SUMMARY E - COLLECTIVE TRAUMA AND VIOLENCE

Summary of project decisions pertaining to Collective Trauma and Violence

During the development and implementation of this review, the following decisions were made on the scope of the literature to be examined for Collective Trauma and Violence.

- As described in Summary D, it was agreed that the determinant 'Freedom from Discrimination and Violence' in the 1999-2000 VicHealth Mental Health Promotion Framework be replaced with three determinants: discrimination; collective trauma and violence; and interpersonal victimisation.

- The determinant 'Collective Trauma and Violence' focuses on the trauma and violence experienced by groups, i.e. whole communities, societies or countries. We found the literature to be structured around types of traumas, and the populations that experience them.

- We identified three major types of trauma: people experiencing acute disaster; people experiencing ongoing conflict and war; and people experiencing dispossession and relocation. The people experiencing these types of traumas share common features and some populations may experience all three types of trauma. However, generally there are separate bodies of literature associated with each type of trauma.

- It was also agreed that the intervention options and evaluations included in this summary would be confined to those pertaining to people experiencing dispossession and relocation, specifically refugees and asylum seekers, and Indigenous peoples[5]. These two groups are included among the key population groups in VicHealth's Mental Health Promotion Framework, 1999-2000.

- The literature on refugees and asylum seekers is relatively recent. There is a body of literature describing the traumatic experiences and adverse health consequences of refugees and asylum seekers. Very little literature exists on intervention programs and we did not identify any reviews or systematic evaluations of programs.

- The overall body of literature on health-related interventions for Indigenous peoples is small and mostly focused on physical health. Indigenous communities have a holistic view of health, and an individual's health is inextricably linked to the health of his/her community and to fundamental relationships with the land. We therefore cast a wider net to look at community-based interventions targeting any aspect of health but excluding biomedical interventions. The number of evaluated interventions we identified was again small.

[5] In this report, the term 'Indigenous' is used to refer to Aboriginal and Torres Strait Islander peoples in Australia, and populations indigenous to other countries, such as the Inuit people in Canada.

1 Concept definition

Details of the references discussed below are given in the following table:

Table E.1.1: Collective trauma and violence experienced by Indigenous peoples – conceptual and empirical issues.

Summary

- The concept of collective trauma and violence includes shared experiences associated with acute disasters (events with sudden onset) as well as chronic or ongoing hazards.

- Acute disasters can be divided into three groups: natural disasters (earthquakes, hurricanes, floods, etc); technological disasters (airplane crashes, industrial accidents, nuclear accidents, etc); and mass violence (shooting sprees, sniper attacks, bombings and other terrorist attacks, mass suicides, etc) (Norris et al, 2002).

- Research on chronic and ongoing hazards has focused on political conflicts and war, ethnic conflicts and violence, and dispossession and relocation from homelands (usually forced). Two key population groups experiencing dispossession and relocation are refugees and asylum seekers, and Indigenous peoples.

- Momartin and colleagues (2002) identified four dimensions/sources of trauma: human rights violations and extreme traumatic experiences; dispossession and eviction; threat to life; and traumatic loss of family.

- It has been noted that western concepts of mental health and mental illness do not sit comfortably with many refugee groups (Summerfield, 2001) and Indigenous peoples (Commonwealth Department of Health and Ageing, 2003; Maher, 1999). For example, Indigenous people view mental health more broadly in terms of social, spiritual and emotional well-being, embedded within a holistic concept of health that is linked to land and kinship obligations (Brown, 1999; Maher, 1999). The different conceptual frameworks of western health practitioners and Indigenous clients may be a key factor in issues such as treatment compliance and patient satisfaction (Maher, 1999).

Strengths, limitations and critique

- Within population groups experiencing collective trauma, individual differences in those experiences as well as individual differences in vulnerabilities and coping strategies will contribute to variations in outcomes.

- Disaster research is best described as a series of case studies; circumstances are often unique, and research tends to be opportunistic and, by necessity, less rigorous scientifically (Norris et al, 2002).

- Research with Indigenous populations in Australia and overseas tends to be specific to the group under study, and generalisability of results is limited by differences that exist across Indigenous groups (Boughton, 2000; Commonwealth Department of Health and Ageing, 2003).

- There exists a significant challenge for western mental health practitioners to reconcile western models of mental health promotion and interventions with culturally diverse client groups and their needs.

2 Key findings and conclusions on the link between collective trauma and mental health

Details of the references discussed below are given in the following tables:

Table E.2.1: Collective trauma and violence (general) – associations with mental health;
Table E.2.2: Collective trauma and violence experienced by refugees and asylum seekers - associations with mental health; and
Table E.2.3: Collective trauma and violence experienced by Indigenous peoples – associations with mental health.

Summary

- The experience of collective trauma is associated with significant social disruption and dislocation including family loss, disruption of daily life, lack of shelter, food shortages and malnutrition, dismantling and destruction of local services and infrastructure (Hollifield et al, 2002; Pedersen, 2002).

- The vast majority of studies on the mental health effects of trauma have focused on post traumatic stress disorder (PTSD); other longer term mental health effects have included depression, anxiety, and alcohol and drug abuse (Hollifield et al, 2002; Norris et al, 2002; Pedersen, 2002; Sabin et al, 2003; Steel et al, 2002; Thibeault, 2000).

- However, with regard to Indigenous populations, the effects of dispossession have been interpreted much more widely to also include domestic violence, youth suicide, assaults, unemployment, poverty and petty crime (Brown, 1999).

- For people experiencing acute disasters, the general trend is for symptoms and impairments to peak during the first year and then decline over time (McKelvey et al, 2002; Norris et al, 2002).

- Increased risk of adverse mental health outcomes is associated with more severe exposure, female gender, middle age, ethnic minority status, secondary stressors, prior psychiatric problems, and weak or deteriorating psychosocial resources (Norris et al, 2002; Sabin et al, 2003).

- Within adolescent samples, family factors appear to be primary determinants of mental and behavioural outcomes (Norris et al, 2002). For very young children, exposure to traumatic events is likely to have detrimental effects on neurobiological and physiological development (Professional Alliance for the Health of Asylum Seekers and their Children, 2002).

- Trauma not only has negative consequences; it can mobilise social cohesion and elicit individual and community forms of resilience and coping (Pedersen, 2002).

Strengths, limitations and critique

- Prevalence estimates of adverse health outcomes following trauma vary widely depending on definitions and measurement tools used; many are culturally inappropriate or untested with non-Western populations (Hollifield et al, 2002).

- There is a relative absence of studies of those populations most affected by war, i.e. people in developing countries, and some specific types of trauma, e.g. bio-terrorism (Pedersen, 2002).

- More sophisticated research is needed about the diverse needs of different populations experiencing different types of trauma; family and community processes during and after trauma experiences; and effective community-based interventions and strategies that help foster resilience and reduce vulnerability (Norris et al, 2002).

3 Suggested policy and intervention options

Details of the references discussed below are given in the following tables:

Table E.3.1: Collective trauma and violence experienced by refugees and asylum seekers – intervention options; and
Table E.3.2: Collective trauma and violence experienced by Indigenous peoples – intervention options.

Summary

Refugees and asylum seekers

- A theoretical basis exists for expecting that people with moderate levels of mental health impairment may benefit from community-based interventions to reduce stress, enhance social support and provide reassurance about future risk, but evidence is lacking (Norris et al, 2002).

- A recent study with Bosnian adolescent refugees identified four elements for a school-based post-war intervention program, using a public mental health approach: multilateral partnerships with local and ministerial stakeholders; systematic and detailed understanding of participants' trauma and loss experiences; training program for local service providers; and indigenous support infrastructure so that the program can be directed and sustained within the community (Saltzman et al, 2003).

- An intervention with Kosovar refugees in Australia focused on establishing a 'therapeutic presence' and building trust and an ethos of working together. An activity-based approach was used, promoting psychological and physical resilience rather than trauma therapy per se (Vicary and Searle, 2000). Importantly, this study and others have shown that the activities need to be determined by the refugees themselves, whose focus tends to fall on work opportunities, schooling and family reunion (Mitchell, 2001; Summerfield, 2001; Vicary and Searle, 2000).

- Successful integration and acceptance of refugees in Australia has been associated with legal and policy frameworks that support multiculturalism, provision of extensive support services to assist immigrants and refugees, and the general goodwill of the Australian population towards immigrants and refugees.

- More recent policies are likely to weaken support structures, create extra burdens on new immigrants, and contribute to increases in mental health problems (Minas and Sawyer, 2002). Similar findings were identified in a study of global trends affecting the integration of refugees and migrants in new host countries (Ferris, 2001).

Indigenous peoples

- A recent consultation paper was issued by the Commonwealth Department of Health and Ageing (2003) on the development of a national strategic framework for Indigenous mental health and social and emotional well-being. It suggests nine principles that should guide better management of mental health issues among Indigenous peoples, including a holistic view of health, self-determination, a culturally valid understanding of Indigenous peoples' health and mental health problems, and respect for Indigenous peoples' strengths, creativity and endurance.

  The paper suggests that mental health promotion should focus on reducing risk factors and promoting protective factors (both defined). It also notes that mental health risk and protective factors are relevant to other social outcomes such as violence, crime and school achievement. Specific actions that could be taken to reduce risk factors and promote protective factors include: preventing homelessness and preserving families; preventing and responding to child abuse; providing safe crime-free neighbourhoods, improving education, income and employment outcomes, and reducing racism.

  The paper also outlines nine key result areas for improving Indigenous mental health, including the following:

  - enhance resilience and protective factors for mental health with focus on children, young people and families;
  - reduce risk factors, especially grief, loss and trauma;
  - build up ACCHs and skilled workforce within ACCHs;
  - enhance capacity of mainstream mental health workforce and services to meet needs of Indigenous people;
  - enhance and coordinate funding; and
  - develop and publish culturally appropriate research and data relevant to Indigenous mental health and improved service delivery.

- Others have emphasised the importance of social inequality and powerlessness as key issues for Indigenous well-being, and have advocated increased education to enhance Indigenous peoples' skills and assertiveness so that they may challenge and modify existing social relations (Boughton, 2000; Devitt, Hall and Tsey, 2001; Malin 2003).

- Studies in Australia and Canada have also recognised the relationship between a history of dispossession and trauma among Indigenous people and high crime and incarceration rates; crime is also linked to substance abuse, conflictual relationships and poor social and mental well-being. There is a need to develop specific prevention and support programs for Indigenous offenders (Kirmayer et al, 2003; Jones et al, 2002).

Strengths, limitations and critique

- Common themes in the suggested interventions and strategies include self-determination, community empowerment, and building relationships based on trust emerge across these different populations.

- Assessment and treatment options for communities experiencing trauma and violence tend to be based on Western concepts of mental and physical health, and often do not match the experiences and expectations of trauma victims from non-Western cultures and countries (Commonwealth Department of Health and Ageing, 2003; Maher, 1999; McKelvey et al, 2002; Summerfield, 2001).

- It is important to recognise that potential support providers for trauma victims are often victims themselves (Norris et al, 2002).

- Work with refugees and asylum seekers, and with Indigenous peoples highlight the primacy of meeting basic human needs (shelter, food, protection, work, education); mental health needs appear to follow these other issues.

4 Implemented interventions and evaluations

Details of the references discussed below are given in the following tables:

Table E.4.1: Collective trauma and violence (general) – evaluations of interventions; and
Table E.4.2: Collective trauma and violence experienced by Indigenous peoples – evaluations of interventions.

Summary

- A wide range of psychosocial and pharmacological therapies are used to deal with trauma-related disorders, but insufficient evidence exists to support any of them as effective options for preventing or treating mental health problems in the short or longer term (Norris et al, 2002; Pedersen, 2002).

- There is little evidence that the mental health interventions provided by humanitarian agencies provide something more valuable than what can be obtained from personal social support networks (Pedersen, 2002).

- Although the use of psychological de-briefing following trauma has become increasingly popular, no firm evidence exists to show that trauma counselling and debriefing work effectively. Recent systematic review published by Cochrane on single-session psychological debriefing following exposure to traumatic events found no benefits in reducing psychological distress or preventing the onset of PTSD. It was concluded that “compulsory debriefing of victims of trauma should cease” (Rose et al, 2003).

- Individual cognitive behaviour therapy (CBT) has received the strongest empirical support but with various qualifiers (e.g. not appropriate for people with extreme anxiety, those at risk of suicide, or those with acute bereavement reaction) (Norris et al, 2002).

- No studies were identified of systematic evaluations or reviews of interventions specifically with refugees or asylum seekers.

- Three systematic reviews of interventions with Indigenous communities were identified. A systematic review published in 1999 identified 13 published studies of controlled clinical trials addressing the health needs of Aboriginal Australians (Morris, 1999). Only two of the 13 papers were published in the last 10 years (both in 1996), and 11 of the 13 papers involved studies with children only. No study included mental health indicators per se. More recently, two reviews have been published on interventions designed to address substance misuse (alcohol, and petrol sniffing) (Gray et al, 2000; Maclean and D'Abbs, 2002). There has also been a recent paper on a substance misuse program that failed (Sibthorpe et al, 2002).

- The effect of most of the interventions with Indigenous groups appeared to be limited, although programs often suffered from poor implementation and inadequate resources, and have not been systematically evaluated.

- Maclean and D'Abbs (2002) argue that 'best buys' for petrol sniffing interventions are likely to be in creating recreational, educational and employment opportunities for Indigenous youth.

Strengths, limitations and critique

- There is very little literature on the evaluation of interventions with refugees and asylum seekers, or Indigenous peoples. Existing studies are confined to one-off small-scale projects with specific communities, and most suffer from poor implementation, inadequate financial and human resources, and inadequate evaluation.

- The failed project reported by Sibthorpe and colleagues (2002) provides important insights into common challenges and significant obstacles associated with working with Indigenous communities.

Some implications for consideration by VicHealth

- The relationship between the experiences of collective trauma and violence on the one hand and adverse mental health outcomes on the other is robust, not withstanding definitional and measurement problems. The evidence suggests that the specific condition of PTSD is a common outcome of collective trauma, but other adverse mental health outcomes have also been reported, including depression, anxiety, substance misuse, and suicide.

- Although the overall quality of evidence is limited, the following themes appear to be common to suggested interventions with refugees, asylum seekers and Indigenous peoples:
  - Health professionals working with refugees, asylum seekers and Indigenous peoples must recognise the cultural framework within which they operate, and that this framework may not be shared by people from other cultural backgrounds. The majority view should not be presumed to be the only valid view.
  - Common experiences among refugees, asylum seekers and Indigenous peoples include significant trauma, significant family breakdown, loss of control over their lives, significant de-valuing of individuals and groups, and ongoing human rights abuses. Refugees, asylum seekers and Indigenous peoples seek respect, self-determination and empowerment.

- While mental health workers have been keen to address the effects of trauma and loss, refugees, asylum seekers and Indigenous peoples are more likely to give priority to other needs, notably shelter, food, protection, work, and education.

- A small number of reviews exist on interventions with Indigenous peoples, and emphasise consistent problems with implementation and evaluation. A recent consultation paper issued by the Commonwealth government on the development of a mental health framework for Indigenous peoples in Australia is a key document, and further development of this framework should be monitored by VicHealth.

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SUMMARY F – INTERPERSONAL VICTIMISATION

Summary of project decisions pertaining to interpersonal victimisation

During the development and implementation of this review, the following decisions were made on the scope of the literature to be examined for Interpersonal Victimisation.

- As described in Summary D, it was agreed that the determinant 'Freedom from Discrimination and Violence' in the 1999-2000 VicHealth Mental Health Promotion Framework be replaced with three determinants: discrimination; collective trauma and violence; and interpersonal victimisation.

- The determinant 'Interpersonal Victimisation' focuses on the trauma and violence experienced by individuals (in contrast to the determinant 'Collective trauma and violence', which focuses on trauma and violence experienced by whole communities, societies or countries).

- Two main groups at increased risk of interpersonal victimisation in nearly every society are women and children. We identified at least four separate bodies of literature relevant to these two groups: interpersonal victimisation (general); intimate partner violence; peer victimisation (bullying); and the adverse experiences of young people.

- Given the existence of a range of evidence reviews focussing on violence perpetuated against women, it was agreed that the intervention options and evaluations included in this summary would be confined to those pertaining to peer victimisation, specifically bullying of children at school.

1 Concept definition

Details of the references discussed below are given in the following tables:

Table F.1.1: Interpersonal victimisation (general) – definitions;
Table F.1.2: Intimate partner violence – definitions; and
Table F.1.3: Peer victimisation (bullying) – definitions.

Summary

- Interpersonal victimisation includes interpersonal violence, peer victimisation, and sexual, physical and emotional abuse of individuals. Definitions of interpersonal violence vary and affect prevalence estimates, e.g. inclusion of spanking of children increases the rates enormously (Emery and Laumann-Billings, 1998; Golding, 1999).

- A substantial body of literature has emerged in recent years on the physical and mental health effects of interpersonal violence and abuse of women. A wide range of terminology is used, e.g. spouse abuse, wife abuse, intimate partner violence, gender-based violence, sexualised violence, domestic violence, and family violence (Bennett et al, 2000; WHO OECD, 2003).

- In the literature, peer victimisation (bullying) refers specifically to the experience among children of being a target of the aggressive behaviour of other children; it includes physical, verbal, indirect and relational victimisation although few studies have examined the latter two types (Hawker and Boulton, 2000). While there is no standard definition of bullying, studies tend to converge on the following elements: a separate and distinct form of deliberate aggressive behaviour; repeated episodes; and there is an imbalance of power between the bully and victim (Smith and Ananiadou, 2003; Rigby, 2002; Lindström, 2001).

  In addition to the roles of bully and victim, other roles are played by playground peers, including reinforcer, defender and bystander or outsider (Menesini et al, 2003; Smith and Ananiadou, 2003).

2 Key findings and conclusions on the link between interpersonal victimisation and mental health

Details of the references discussed below are given in the following tables:

Table F.2.1: Interpersonal victimisation (general) - associations with mental health;
Table F.2.2: Intimate partner violence - associations with mental health;
Table F.2.3: Peer victimisation (bullying) - associations with mental health; and
Table F.2.4: Young people at increased risk - associations with mental health.

Summary

Interpersonal violence

- Research on interpersonal and family violence generally draws on three sources of data that yield widely divergent results: 'official' statistics; information gathered by professionals who come into contact with victims; and population sample surveys (Emery and Laumann-Billings, 1998). The variability in prevalence rates across families, communities and countries suggests potentially modifiable factors (Bennett et al, 2000; Emery and Laumann-Billings, 1998; WHO OECD, 2003).

- Interpersonal violence is associated with a diverse range of mental health problems including depression, suicidal ideation and behaviour, PTSD, alcohol and drug abuse, anxiety, aggression, and somatic and physical symptoms. Some types of trauma are more strongly associated with some types of outcomes e.g. sexual assault in women is strongly associated with PTSD, while sexual abuse in children is associated with sexually inappropriate behaviour (Astbury, 2001; Bennett et al, 2000; Coker et al, 2002; Emery and Laumann-Billings, 1998; Golding, 1999; WHO OECD, 2003).

- Considerable overlap exists between spouse abuse and child abuse (Emery and Laumann-Billings, 2000).

- Interpersonal violence is often conceptualised within family systems framework, but it has been argued that a wider ecological perspective is needed, e.g. violent families tend to live in communities with higher rates of community violence (Emery and Laumann-Billings, 1998).

Violence against children

- For children who are victims of interpersonal trauma, far more research exists on sexual abuse than physical violence although the prevalence of the latter is higher. Girls are more likely to be victims of sexual abuse, and boys are more likely to be victims of physical violence (Shaw and Krause, 2002).
- Childhood sexual abuse is associated with physical, sexual and psychological problems (especially depression and anxiety) in adulthood; victims of child sexual abuse are also 2-4 times more likely to be sexually abused in adulthood (Bennett et al, 2000; WHO OECD, 2003).
- Childhood physical violence is associated with a lower sense of personal control in adulthood, less emotional support, and more negative interactions with family and friends; these factors in turn are associated with depressive symptoms and physical ill health in adulthood (Shaw and Krause, 2002).
- Well established relationships exist between child mistreatment and poverty, high unemployment, inadequate housing and social isolation (Emery and Laumann-Billings, 1998).

Peer victimisation (bullying)

- A recent review found that bullies represent 7-15% of sampled school-age children and victims represent about 10%; the prevalence decreases from around the age of 14 years (American Medical Association, 2002). Other studies have shown that approximately 11-14% of boys and 4-5% of girls report peer victimisation, but wide variation across schools suggests potentially modifiable factors (Lindström, 2001).
- Some have suggested that schools with low social capital tend to have higher incidence of peer victimisation, as well as other violence, vandalism, theft, burglary and arson (Lindström, 2001).
- Victims are usually boys, smaller, younger, weaker, outnumbered, less confident and/or unpopular. Victims tend to learn how to cope as they grow older although they maintain higher than average rates of depression in the longer term. In contrast, perpetrators tend to remain aggressors (Lindström, 2001).
- Another meta-analysis showed that trauma from bullying was most strongly associated with depression. Other psychosocial correlations included low self-esteem, poor self-concept, loneliness, and anxiety (Hawker and Boulton, 2000). Adverse psychological consequences of bullying have been confirmed using a variety of research methods, participants from diverse populations, and participants from both sexes and all age groups (Hawker and Boulton, 2000; Lindström, 2001).
- Bond and colleagues (2001) have noted that studies of the mental health effects of peer victimisation have generally focused on primary school children, and question whether the early increase in depressive symptoms in adolescence is a more appropriate time to assess children for associations between bullying and mental health effects. They conducted a study in Victoria with students in Years 8 and 9 (14-15 years), and showed that students with a history of victimisation were 2.3 times more likely to be depressed than other students (95%CI 1.2-4.3). After statistical adjustment for confounding factors, victimisation remained predictive of depression and anxiety in girls but not boys (Bond et al, 2001).

Strengths, limitations and critique

- Empirical studies of interpersonal violence and trauma have often been hampered by incomplete and/or biased samples. Studies of the longer term effects of childhood trauma also usually rely on people's memories of their childhood experiences, which are open to error (Shaw and Krause, 2002). Despite these methodological problems, the overall evidence of the adverse effects of interpersonal violence on mental and physical health is robust; more of the same research is not needed (Hawker and Boulton, 2000).

- There is little discussion in the bullying literature of whether the developmental changes experienced by children over time might influence the types of mental health effects associated with bullying, as mentioned by Bond and colleagues (2001).

3 Suggested policy and intervention options

Details of the references discussed below are given in the following tables:

Table F.3.1: Interpersonal victimisation (general) - intervention options; and
Table F.3.2: Peer victimisation (bullying) - intervention options.

Summary

Interpersonal and family violence

- For families in crisis, the more serious and chronic the problems, the less successful the intervention program. 'Supportive' interventions for families can include individual, family and group therapies, parent training, and home-visiting programs. Some 'adversarial' interventions, such as removal of children, are known to have tremendously adverse effects on children and families (Emery and Laumann-Billings, 1998).

Peer victimisation (bullying)

- Specific interventions suggested for schools include training teachers about bullying, closer monitoring of student behaviour by teachers, class discussions, role playing and games that help students be more aware of the harm caused by bullying, support for victims, and consistent enforcement of sanctions. Around 12-14 comprehensive programs that included most or all of these elements have been implemented around the world and systematically evaluated (see Section 4 below on intervention evaluations).

- Interventions suggested specifically for perpetrators (bullies) have included teaching self-control, learning to see the perspective of others, behaviour modification, and enforcement of sanctions; however no systematic evaluations have been undertaken to establish the effectiveness of these interventions (Lindström, 2001).

- A different approach for bullies and school peers, described by Morrison (2002), is based on a 'restorative justice model of conflict resolution. This program was pilot tested in the ACT, and early results suggested positive effects on victim- and bully-types of behaviour.

- Others have focused on the possible value of targeting interventions at peers who play various roles in bullying episodes, e.g. increasing the proportion of defenders who are willing to come to the assistance of victims (Hawkins et al, 2001; Menesini et al, 2003; O'Connell et al, 1999; Salmivalli, 1999).

- Vernberg and Gamm (2003) argue that multiple factors exist at different levels (e.g. cultural, community, school and individual) that can limit or impair the use of school-based approaches to bullying. The authors list various barriers at each of these levels and offer suggested strategies that may assist.

4 Implemented interventions and evaluations

Details of the references discussed below are given in the following table:

Table F.4.1: Peer victimisation (bullying) – evaluations of interventions.

Summary

- Two recent detailed reviews have been published of large-scale school-based intervention programs targeting school bullying, that have been implemented in various countries. The programs included in the two reviews are very similar (Smith and Ananiadou, 2003; Rigby, 2002).

- The first comprehensive anti-bullying program was implemented in Bergen, Norway, in 1983. It involved 2,500 students aged 11-14 years, from 42 primary and secondary schools. Strategies included the development of school policies on bullying, curriculum work, group and individual work, playground work and peer support schemes. The Bergen program showed a 50% reductions in students' reports of bullying for all age and sex groups, a marked reduction in other antisocial behaviour (theft, vandalism, etc), and improvement in the overall 'school climate'.

  Bergen became the 'model' for most other programs around the world, e.g. Rogaland (Norway); Sheffield, Wolverhampton, Liverpool and London (England); Toronto (Canada); Schleswig-Holstein (Germany); South Carolina (USA); and Flanders (Belgium).

  An evaluation of the Bergen model against the characteristics of a 'good model program' indicated that the Bergen model has many strengths and did qualify as a good model. However, three weaknesses were identified: no clear link exists between the program objectives and program methods, no clear description is given of the skills required to conduct the program, and the component in the program dealing with parental involvement has proven less feasible to implement (Stevens et al, 2001).

- Results from the other anti-bullying programs around the world have been mixed. None has been as successful as the Bergen program, most have shown modest improvements, some have shown no effect, and some even adverse effects.

  Schools that put more effort into program implementation tended to have more positive results. Some kinds of bullying appeared to be more readily reduced than others, e.g. physical forms respond better than verbal forms to anti-bullying programs. Reductions were more commonly found in the proportion of children

being bullied and less often in the proportion of bullies. More positive results were reported with younger (primary school) children than secondary school children. This may be due to developmental characteristics and/or organisational features of primary versus secondary schools (Smith and Ananiadou, 2003; Rigby, 2002).

- Several studies that have included control groups have shown that, without intervention, bullying episodes tend to increase during primary and early secondary school years (Menesini et al, 2003; Rigby, 2002).

- Two main approaches to bullying have been used – the so-called 'no blame' approach, and one emphasising rules and the use of negative sanctions (the Bergen program is an example of this type). Rigby (2002) notes current evidence does not indicate that one is more effective than the other. Current evidence also does not indicate which components of intervention programs are responsible for the reported effects.

Strengths, limitations and critique

- Rigby's paper (2002) is an important document; not only does it provide a good summary of anti-bullying programs around the world, but it also summarises policy and program directions for anti-bullying initiatives in Australia.

Some implications for consideration by VicHealth

- The relationship between the experiences of interpersonal victimisation and adverse mental health outcomes is strong. International attention over the past two decades has revealed the wide-spread abuses of women and children, predominantly by men known to them. There is a vast literature about the necessary systemic changes - cultural, political and social - that are needed to alter these well-entrenched patterns of mistreatment.

- In consultation with VicHealth, the intervention options and evaluation of interventions in this summary focused on peer victimisation, that is, bullying experienced by children at school. The adverse effects of peer victimisation on mental health include depression, low self-esteem, poor self-concept, loneliness and anxiety. There is a rich literature on anti-bullying programs that have been implemented and systematically evaluated. Importantly, Rigby (2000) has reviewed these programs and formulated a range of recommendations for the Australian context, although they focus largely on the school environment. Most anti-bullying programs are embedded within an ecological or social framework, and involve a range of initiatives that target the individual, the class, the school and the community. There appears to be scope for more work with the wider community.

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TABLE A – SOCIAL CAPITAL

Table A.1: Social Capital – definitions and models

Publication	Aim or Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
A glossary for health inequalities. **Kawachi** I, Subramanian SV, Almeida-Filho N (2002) *Journal of Epidemiology & Community Health* 56; 9: 647-652.	Address key questions pertinent to the health inequalities literature	Glossary includes one of the simplest definitions of social capital ie "the resources available to individuals and to society through social relationships". They challenge those who conceive the resources of social capital as purely *psychosocial* (eg trust, norms of reciprocity and emotional support); and propose social relationships also provide *tangible* resources (such as cash loans, labour in kind and access to information).	Concise and clear – considers links between social capital and inequalities.	Main focus of paper is on inequalities and health (rather than social capital and mental health).
Social Capital and Social Wellbeing; discussion paper **ABS** (2002) Australian Bureau of Statistics.	Outlines rationale, approach and plans by the ABS to collect data on social capital. Examines policy questions and issues that may be informed by data on social capital and how it may	The role of the ABS is to support informed decision making and policy development through the provision of statistics that address all areas of economic and social concern (p2) ABS is developing a social capital framework and indicator set for collecting data (for publication in October 2003). Data collection planned for 2005/06. Their main interest is how to best develop useful measures of social capital that will meet the needs of stakeholders. Following review of literature & consultations, the ABS	Outlines Australian developments to collect data that can be useful for planning and evaluating future programs	Aim to collect generic data on social capital – no specific focus on mental health. Although they do indicate the measures they develop could be incorporated into future specialised

	be used (p11-19).	determined to adopt the Organisation for Economic Co-operation and Development's definition of social capital: ie *'networks, together with shared norms, values and understandings which facilitate cooperation within or among groups'* (OECD, 2001). OECD highlight that social capital is: - relational rather than the property of individuals or businesses - the result of societal investments of time and effort, but less directly than other forms of capital because it relies on historical, cultural, and social factors which give rise to norms, values and social relations that bring people together in networks or associations which result in collective action, and that it - increases if it used by reinforcing the networks, norms and values, and decreases if it is not used - ABS also adopt Woolcock's dimensions of bridging, bonding and linking SC (below), and give emphasis to both formal and informal forms of social engagement. - Policy consultations identified that stakeholders are interested in understanding why some communities adapt better to change than others, and why some do better with a given set of resources. They also want to know what influences shape community confidence in achieving their goals. - The health related issues that stakeholders sought to inform with data on social capital were: prevention of mental health, drug use, suicide and premature death, and how social capital relates to demand and use of services, & confidence in welfare and preventive services. - The report concludes if the links between social capital and community confidence and adaptability are shown to be sufficiently strong, then building social capital in communities will become an increased focus of policy (p11).		surveys ie health surveys.
Social Capital; a discussion paper. **Aldridge** S, Halpern D, Fitzpatrick S (2002)	Topic overview - aims to facilitate debate on policy implications and potential initiatives (see also below)	Provides a summary of literature on what is social capital and why it is important. Identify 3 components of social capital: - Networks (network members) - Norms (rules and understandings) - Sanctions (rewards and punishments for complying/breaking		UK paper.

Cabinet Office Performance and Innovation Unit, London. Website: http://www.number-10.gov.uk/su/social%20capital/socialcapital.pdf		norms) Distinguishes between positive social capital that is a *public good* (all members of community have access) versus *club good* (group controls social capital and restricts access to others). A summary of trends in social capital by country on p 34. The data indicate that all measures of social capital in *Australia* are *declining*: voluntary groups, social movements, volunteering and informal socialising, inter-personal trust and in political institutions. In all other countries listed (other than the US which is like Australia) the measures of social capital are stable or rising.		
Measuring social capital within health surveys: key issues **Harpham** T, Grant E, Thomas E (2002) *Health Policy & Planning* 17(1): 106-111.	Overview of measures used in key social capital and health studies; and summary of issues to consider in future health surveys and social capital surveys.	Identify two components of social capital: - *structural* component (extent and intensity of associational links or activity ie what people 'do' in social relations) - *cognitive* component (perceptions of support, reciprocity, sharing and trust ie what people 'feel' about social relations) Highlight the 'bonding' and 'bridging' dimension that overlaps with the 'horizontal' and 'vertical' concepts social capital (described below in Woolcock, 2001). Emphasise not only relationships within communities, but also the links between communities and governments. Need to take account of how the *political context* impacts on the relationship between social capital and health. - Note value of identifying and measuring social capital as an *ecological* characteristic; to differentiate social capital measures from measures of social networks and social support (attributes of individuals). - Describe existing *measures* of social capital from the literature that were collected from individuals but *aggregated* to the neighbourhood or state level, and analysed as an ecological characteristics. Eg The concept of 'collective efficacy' measured social cohesion + informal social control. - Reinforce Lochner et al (1999 below) in their call for more truly ecological-level measures which tend to be collected via observation rather than aggregated individual-level measures from surveys. - Also advocate for *comprehensive* measures of social capital in order to fully capture the relationship between its different		

		dimensions and health. Current reliance in health surveys on using only one or two questions to measure social capital yields data that is of limited value. - The Bullen and Onyx (1998) NSW study is cited as a comprehensive measure of the 'bridging' and 'bonding' dimension of social capital.		
Social capital for health; insights from qualitative research **Swann** C, Morgan A (2002) NHS Health Development Agency (Builds on work by Campbell et al, 1999, for the UK Health Education Authority, see below)	Presents a series of qualitative studies that explore the concept of social capital and its importance to health, in various different populations in the UK. (Seeking to identify variations in social capital and its relations to health by gender, age and ethnicity).	Qualitative studies include: - *Children's experiences of 'community': implications of social capital discourses* - *Social capital, exclusion and health: factors shaping African-Caribbean participation in local community networks* - *Men and masculinities: accounts of health and social capital* - *Social capital, generations and health in East London* - *Moving beyond the survey in exploring social capital* The common insights derived from the above studies were: - The concept of 'Power' is identified as a central theme in relation to social capital and its relationship to health ie the ability to have influence, motivate and change - themselves, others, and community structures (eg men who are empowered in other areas of their lives may lack power and social resources in relation to their social and health priorities; young people consider themselves in relation to their ability to change or control the structures around them. Many groups experiencing health inequalities are likely to exist within contexts of dis-empowerment. - There are substantive material and social barriers to the acquisition and utilisation of social capital for most of the populations discussed. Methodological issues raised in relation to the study of social capital and health: - Some aspects of social capital are more relevant that others to different populations groups at different life stages. - There is often a lack of fit between the constructs commonly considered to indicate social capital and the lived experience of health and community (see last paper on 'moving beyond the survey'). - Differences in definitions of 'community' are important ie networks and communities inhabit different spaces and are often not geographic.		

		- Need community-level indicators of social capital. - Also important to take account of potential downside of social capital which may not be conducive to health eg it can be used to exclude outsiders and as a means of oppressive social control.		
Social trust and self-related health in US communities: a multilevel analysis. **Subramanian** SV, Kim DJ, Kawachi I (2002) *Journal of Urban Health*: Bulletin of the New York Academy of Medicine; 79(4), Supplement 1: S21-S34.	Examines 5 different questions about SES, social capital and health, including: - whether trust at the community level is an independent determinant of health after taking account of individual perceptions of trust.	A multilevel analysis of data from the 2000 Social Capital Community Benchmark Survey, n = 26,230 across 40 communities. Social capital was measured at 1) individual level as 'general interpersonal trust' and 'degrees of trustworthiness in neighbours', and 2) Aggregate community-level (aggregated individual responses to questions about interpersonal trust) - Community level of trust was significantly and negatively associated with self-rated poor health ie in communities with higher levels of trust, individuals were less likely to report poor health, after controlling for demographic and SES characteristics. - However, including individual trust perception rendered the main community effect of social capital statistically insignificant, suggesting that the aggregate social capital effect (previously reported in literature) is an artefact of individual social capital perceptions (pS29). [*Indicates that the individual and aggregate measures probably reflect the same phenomenon ie individual perceptions of social capital – reinforces the need for truly ecological, observational measures of social capital!*] - Found significant interaction effect between community (aggregate) social capital and individual trust: ie the protective effect of community social capital is present for high trust individuals, but for low-trust individuals the effect is reversed and thus high social capital communities are not favourable for low trust individuals,.	Generates hypothesis that distinguishes between the health promoting effects of living in communities with high social capital (*aggregate measures)* for high-trust individuals; versus the potentially detrimental effects of the same community for low-trust individuals (who may feel unable to conform, ostracised & alienated from the norm)	Focused on self-reported health generally, rather than mental health specifically.
The interrelations of social capital with health and mental health; discussion paper. **Cullen** M, Whiteford H (2001)	Overview of the literature & informed by the outcomes of a 'social capital and mental health workshop' held at the World Bank in Washington DC, July	The World Bank (2001) refers to social capital as *networks of people deriving benefit from common interaction with each other*. Also distinguish between 2 interacting components of social capital: - *Structural* ie roles, rules, precedents, procedures, and networks.	Australian context. Valuable overview that focuses on relationship between social capital and mental health - report concludes with 6 recommendations for	

National Mental Health Strategy, Commonwealth of Australia.	2000.	Structural social capital has 2 dimensions: horizontal (bonding or bridging) social capital, and vertical (linking) social capital. - *Cognitive* ie norms, values, attitudes, beliefs that contribute to cooperative behaviour. Introduction summarises four main perspectives on the potential operationalisation of social capital into policies and programs (citing Serageldin & Gootaert, 2000): - *Micro*: local community associations and underlying norms that facilitate coordination and cooperation for mutual benefit. Focuses on positive aspects of social capital. - *Meso*: broader application that enables examination of wider spectrum of social dynamics that extends its scope to include vertical associations - characterised by hierarchy & unequal power distribution among members of society. Examines positive and negative aspects of social capital in that it can help some and harm others. - *Macro*: focuses on social and political environment that shapes social structures and enables norms to develop. Includes formalised structures such as government, political regime, rule of law, court system, civil and political liberties - *Integrative*: recognises that micro, meso and macro institutions co-exist and interact. Accounts for positive and negative aspects of social capital and importance of forging ties within and across communities – but recognises that the capacity of various social groups to act in their interest depends crucially on the support or lack thereof from the state and private sectors. Similarly the state depends on social stability and widespread popular support. Authors identify a quandary that exists in researching social capital ie the strongest analytical results are available from micro-level studies; and that being overly inclusive in the scope of our research and measurement of social capital may weaken these results. However, the macro environment has direct and indirect effects on the way community level social capital operates and needs to be taken into account.	further research (see tables below)	

The place of social capital in understanding social and economic outcomes. **Woolcock** M (2001) *Canadian Journal of Policy Research,* Spring; 2(1): 11-17.	Definition and model of 3 types of social capital An introduction to theoretical and empirical literature on social capital in relation to economic development issues.	Social capital defined as *'norms and networks that facilitate collective action'.* Authors note their proposed definition of social capital focuses on what it *is*, not what it *does*. Thus 'trust' which was included in Putnam's 1995 definition is presented as an outcome of social capital. (Note: Putman (2001) agrees, although he says trust is such a close consequence of social capital it can be used as a 'proxy' measure.) Paper describes three types of social capital - *Bonding* (relations and strong bonds among family members, close friends and neighbours, people like ourselves) - *Bridging* (weaker ties among distant friends, acquaintances, associates, colleagues 'social oil', a *horizontal* concept of links with people different to ourselves) - *Linking* (connections between institutions and members of community, or between groups with different levels of power or social status, a *vertical* concept. Linking social capital allows individuals or groups to leverage resources and information from institutions beyond their community radius) Presents unifying argument from the body of research on social connectedness: "the well-connected are more likely to be housed, healthy, hired and happy".	Valuable introduction to concept of social capital and its various forms – widely cited in the subsequent literature.	Focus of major part of paper is on economics rather than health.
Social cohesion, social capital and health. **Kawachi** I, Berkman LF (2000). In: Berkman LF, Kawachi I *Social Epidemiology*. New York; Oxford University Press	Overview of the empirical literature.	A key point is that social cohesion and social capital are *collective* or *ecological* dimensions of society ie social capital is *external to individuals in a society and is thus distinguished from social networks and social support*, which tend to be measured at the level of the individual. Social capital is also viewed as a public good ie there is an aspect of non-excludability in its consumption. They describe it as a by product of social relationships, rather than something that is invested in for its own sake. Stress that outstanding questions of definition and measurement exist. The various definitions of social capital (listed on p176) mix together the *structure* and the *function* of social relations ie membership of civic associations and moral	Valuable summary that highlights the collected nature of social capital	

		resources such as trust and reciprocity. Is social capital the *infrastructure* or the *content* of social relations, the medium or the message – or both? If social capital is the trust that is created as a by product of organisational membership, it is challenging to distinguish between the *sources* of social capital and the *benefits* derived from them.		
Bowling Alone: the collapse and revival of American community. **Putnam** R (2000). New York: Simon & Schuster. Website: http://www.bowlingalone.com/socialcapital.php3 Ideas first outlined in 1995 paper: "Tuning in, tuning out: the strange disappearance of social capital in America." in Political Science and Politics.	A text that expands his original thesis that Americans have become increasingly alienated from one another and disconnected from social and political institutions. Based on data from the Roper Reports and DDB Needham Life Style survey.	"*Social capital refers to the collective value of all 'social networks' (who people know) and the inclinations that arise from these networks to do things for each other ('norms of reciprocity')*." (from website) Social capital emphasizes not just warm and cuddly feelings, but a wide variety of quite specific benefits that flow from the trust, reciprocity, information, and cooperation associated with social networks. Social capital creates value for the people who are connected and sometimes for bystanders as well. Identifies social capital as working through multiple channels eg: - Information flow depends on social capital (eg learning about jobs, learning about candidates running for office, exchanging ideas at college, etc.) and norms of reciprocity (mutual aid) are dependent on social networks. - Bonding networks connect folks who are similar and sustain in-group reciprocity. - Bridging networks connect individuals who are diverse and sustain generalized reciprocity. - Collective action depends on existing social networks (eg the role that the black church played in the civic rights movement). Although collective action can also foster new networks. - Broader identities and solidarity are encouraged by social networks that help translate an "I" mentality into a "we" mentality.	Putnam's work has generated much of the current policy interest in social capital – and he is widely cited in the other literature.	
Social capital and health promotion: a review. **Hawe** P, Shiell A (2000)	Review literature relevant to current interest in social capital among health researchers & practitioners.	Identify dimensions of social capital from existing literature eg - *relational* and *material* elements of social capital (eg embeddedness and autonomy are forms of relational social capital; which may occur at micro as well as macro levels) - *sources* and *consequences* of social capital - what social capital *is* and what it *does*		

Social Science & Medicine; 51: 871-885.		Also discuss social capital as a 1) 'metaphor'; as 2) 'rhetoric'; and as a 3) 'science' (ie as a variable in public health research & practice). 1) Social capital has some of the characteristics of a 'public good' (or 'collective good'). It resides in network-relationships rather than individuals and ownership of the stock of social capital is not transferable between settings. Also, the more it is used, the larger a stock of social capital becomes: ie there is a 'multiplier effect'. It can however, be excluding in that some social groups or members within a group may have the power to exclude others -and thus deprive them of its benefits. 2) The rhetoric of social capital is used across the political spectrum – it is important to question and clarify the message that lies under a rhetorical use of social capital. Social capital is increasingly identified as a prerequisite for economic development. 3) Social capital as a science is developmental and imprecise. The current interest in the topic draws on literature on the social determinants of health and the relationship between SES inequalities and health. There are 3 key hypotheses – 1) individual income hypothesis; and two relative income hypotheses: 2) psychosocial environment hypothesis; 3) material resources hypothesis. These hypotheses are more likely to be complementary rather than competing. Social capital adds to the social determinants literature an explicit focus on the social environment / ecological factors. But it has been measured in a wide variety of ways and studies are based on diverse hypotheses about the relationship between social capital and health status. It is essential that the *hypotheses* and the *rationale* for *measures* used and the anticipated *causal pathways* between social capital and health are made *explicit*.		
Measuring social capital at the individual level: personal social capital, values and psychological distress.	Examine whether 'personal social capital' is a predictor of psychological distress.	Although it is recognised that social capital is often conceived as an ecological, community-level concept, the focus here is on social capital conceived at the individual-level (ie measures of community participation, social support & trust in others; non aggregated data) and how they correlate with		Focus on individual-level measures of social capital rather than societal-level.

Berry HL, Rickwood DJ (2000) *International Journal of Mental Health Promotion* 2(3); 35-44.		measures of psychological distress. Results below (Table A.2.2 - social capital and mental health – empirical studies)		
Social capital: a guide to its measurement. **Lochner** K, Kawachi I, Kennedy BP (1999) *Health and Place*; 5: 259-270.	A guide to the operationalisation and measurement of social capital.	A key point is that community characteristics such as social capital should be distinguished from individual characteristics and measured at the *collective* or *community* level. See also Kawachi & Berkman (2000) emphasis on collective measures Very few available measures are truly collective or contextual (rather than merely relying on aggregating the responses of individuals collected in survey methods). Examples of observable features of a community include: extent to which neighbourhood sidewalks are cleared after a snow storm (reciprocity), or whether local petrol stations require repayment before filling a tank (trust). Paper focuses on four existing constructs which reflect different but overlapping aspects of social capital: - collective efficacy - psychological sense of community - neighbourhood cohesion - community competence		
Social capital and health. **Campbell** C, Wood R, Kelly M (1999) Health Education Authority, UK. The first report in a program of research aimed at improving the evidence base for social approaches to public health and health promotion – program was subsequently taken over by the HDA (see above).	Qualitative research to examine links between aspects of social capital (trust, reciprocity, local democracy, citizenship, civic engagement, social relationships, social support) and health outcomes, access to services, information, and power.	Research based on interviews and focus groups conducted in two less affluent ward-level local communities in Luton, England – one with relatively high levels of health and one with relatively poor levels of health. Conclusions are as follows: - There were variations in the levels of different dimensions of social capital in the low-health and high-health communities. Indicates a need to disaggregate the concept of social capital as some dimensions of community cohesion may be more health enhancing than others. For example, *trust*, *perceived citizen power*, *civic engagement* were higher in the high health community; *reciprocal help* and *support* were same in both communities; and contrary to the study hypothesis, *local identity* and *local facilities* were higher in the low-health community.		

		- The networks and associations constituting social capital are both local and non-local in nature. - Different types and forms of network may be more health enhancing than others ie those that are diverse, broader, and geographically dispersed may be associated with better health outcomes than reliance on only limited local networks. - Need an expanded typology of networks eg informal interpersonal networks of friends and neighbours (cited in both wards), voluntary organisations (seldom cited in either ward), community linked activist groupings and initiatives (cited in high health ward only). - Provision of community facilities will not constitute social capital; attention must be paid to how such facilities are established/run so locals are 'active participants' rather than 'passive recipients'. - Putman's concepts of community cohesion, trust and local identity were, within wards, restricted to the informal interpersonal type of networks (neighbours and friends) and excluded residents outside one's personal acquaintance. - Social capital is not a homogenous resource that is equally created, sustained and accessed by all members of a community. Within communities, there were *strong differences by age, gender and ethnicity*.		
Measuring social capital in five communities in NSW. **Bullen** P, Onyx J (1998) Website: http://www.mapl.com.au/A2.htm A valuable social capital page on the same website provides links to other reports & resources http://www.mapl.com.au/	Study from a management consultancy business "Management Alternatives Pty Ltd" specialising in work for the community based, non-profit, welfare and church organisations and government, especially those providing human services. (established 1988)	Principal findings from the study were: - Social capital is an empirical concept. - It is possible to measure social capital in local communities. - There is a generic social capital factor that can be measured. - There are also eight distinct elements that appear to define social capital. These are: A. Participation in local community; B. Proactivity in a social context; C. Feelings of Trust and Safety; D. Neighbourhood Connections; E. Family and Friends Connections; F. Tolerance of Diversity; G. Value of Life; H. Work Connections - Four of the elements are about participation and connections in various arenas ie: A. Participation in local community; D. Neighbourhood Connections; E. Family and Friends Connections; H. Work Connections.		

A13.htm **Note** - Full report can be purchased @ $20 (academic report focusing on theory and analysis) or $25 (agency report on findings and implications).		- Four of the elements are the building blocks of social capital ie B. Proactivity in a social context; C. Feelings of Trust and safety F. Tolerance of Diversity; G. Value of life. - Social capital was not generally correlated with the demographic variables such as age, gender, etc. There are some exceptions, for example women are less likely to feel safe in their local communities than men; people with more children are likely to participate more in the local community than those with less children. - There are significant differences in levels of social capital between the five communities that were surveyed. For example, Deniliquin and West Wyalong have higher levels of social capital overall than the other three communities.		
The forms of capital. **Bourdieu** P (1986) In: J Richardson, *Handbook of theory and research for the sociology of education* New York: Macmillan. Social capital in the creation of human capital. **Coleman** J (1988) *American Journal of Sociology*; 94: S95-S120.	Commonly cited definitions from 1980s Secondary source - cited in Veenstra (2001)	Bourdieu defines social capital as *'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition – or in other words to membership of a group'*. Coleman defines social capital by its function. *'It is not a single entity but a variety of different entities, with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors – whether persons or corporate actors – within the structure. Like other forms of capital, social capital is productive, making possible the achievement of certain ends that in its absence would not be possible….[It] inheres in the structure of relations between actors and among actors.'*	Valuable earlier sources – although definitions have been refined and simplified in the last few years.	

Table A.2.1: Social Capital – associations with mental health (summaries, overviews of evidence)

Publication	Aim or Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
Social Capital; a discussion paper. **Aldridge** S, Halpern D, Fitzpatrick S (2002) Cabinet Office Performance and Innovation Unit, London. Website: http://www.number-10.gov.uk/su/social%20capital/socialcapital.pdf	Topic overview - aims to facilitate debate on policy implications and potential initiatives	Includes summary of evidence on relationship between social capital and key policy outcomes (GDP, Crime, Health, Education) on Individual, Community (mezze), National (macro) levels (p 28-29). In relation to Health - concludes social capital is strongly causally implicated for individual level physical and mental health outcomes (mediated through both instrumental support and impact on stress reaction) – highlighting importance of bonding social capital. In relation to Community and National level outcomes, there is some empirical evidence of an association but findings are variable. (Authors note overlap with literature on inequality and health.) Provides summary of the downside of social capital ie the dysfunctions resulting from one group using social capital against others or for narrow self-interest eg facilitating rather than reducing crime, educational underachievement and health damaging behaviours. Concludes - if social capital is to bring net benefits to economy and society as a whole, needs to be accessible by all members of society rather than appropriated by one group. Bridging and linking social capital are required to transcend religious, ethnic, social, structural and other divides.	Identifies several measurement, methodological reasons why empirical findings from social capital literature still need to be treated with a degree of caution (p 30) - but argues that the considerable and growing convergence from variety of methods offsets weaknesses of individual studies.	Broad focus, not specific to mental health
Outcomes for the sociology of mental health: are we meeting our goals? **Schwartz** S (2002). *Journal of Health and Social Behavior*; 43: 223-235.	Discussion of the choice of measures that are /should be made in studies of the social determinants of mental health.	Her review of studies published in the American Sociological Association (Journal of Health and Social Behavior) indicated that there is not adequate emphasis to phenomena that are uniquely social. Sociological phenomena tend to be reduced to psychological constructs such as mastery, self-esteem, and powerlessness; and most studies assess status variations in role strain, powerlessness, or lack of control at the individual level only. Even variables that are more readily assessed as group level characteristics ie social networks tend to be measured as individual or inter-personal phenomena. Emphasises the importance of conducting more studies which identify those aspects of society (as opposed to the		

		characteristics of individuals that live in the society) that produce harm. *Examples* Measures of exposure (of psycho-social factors that impact on mental health): - *Sociological* (group level measures of the characteristics of social groups) For example, comparisons of average neighbourhood income, state or LGA level opportunities for social and political participation and influence, neighbourhood infrastructure and networks, measures of social capital - *Psychological* (individual level measures of the characteristics of individuals) For example, survey data on individual income, social ties or social networks, experiences of discrimination Measures of outcome (measures of individual or community mental health) - *Sociological* (group level measures of mental health) For example, variations in suicide rates within different communities or socially stratified groups; community levels of violence, crime or vandalism; - *Psychological* (individually measured stress, anxiety and depression)		
Social capital and mental health. **McKenzie** K, Whitley R, Weich S (2002) *The British Journal of Psychiatry;* 181: 280-283.	Overview of conceptual developments and available evidence of causal links between social capital and mental health.	Despite limitations of the literature (see below), the summary of available studies indicates strong correlations between social capital and mental health and/or wellbeing. - Authors note however, that studies identify correlations and associations between these variables, and do not demonstrate causal relationships. Longitudinal/historical/life-course approaches will be required to examine causal hypotheses between social capital and mental health. Authors note limitations of the current literature on social capital and its association with mental health - Not all dimensions of social capital have been examined eg most studied are 'trustworthiness of others', & some research on 'participation in organisations' and 'sense of community cohesion'. - Community measures tend to be aggregated responses to survey questions across administratively determined geographical boundaries; these often will not truly measure the nature of the social environment.		

		- Many studies assume social capital (in the form of networks, trust and support) is based on geographically defined areas, while social capital may be derived from communities based on ethnic, lifestyle, religion, common interests, which may not be geographically based. - Most studies focus on horizontal links within communities rather than vertical links, but the health benefits derived from social capital are likely to be determined to some degree by policies and interventions of governments and the power relations and opportunities within a society. - The impact of social capital is likely to be felt differently by different sub-groups yet this is under-explored.		
The interrelations of social capital with health and mental health; discussion paper. **Cullen** M, Whiteford H (2001) National Mental Health Strategy, Commonwealth of Australia.	Overview of literature & informed by the outcomes of a 'social capital and mental health workshop' held at the World Bank in Washington DC, July 2000.	(p 22) "In the context of mental health, adding the dimension of social capital integrates the biopsychosocial determinants of mental disorder (genetics, neurobiology, psychological factors, social environment) in a way which brings an understanding of population mental health beyond the aggregation of individual health characteristics or risk factors." The literature on the relationship between social capital and mental health is still limited, but growing. The World Bank Social Capital and Mental Health Workshop identified the following points re what is known of the relationship between social capital and mental illness (p23) - the mechanisms that forge interaction are not unidirectional - causality and reverse causality need further examination - there are immediate effects – especially for the young - studies examining these interrelations should consider the long-term socio-economic and socio-cultural effects, and thus be longitudinal - the effects of vulnerability can be long term - precipitants / perpetuators can be short term Their overview highlights the empirical evidence on 2 aspects of the relationship between social capital and mental health: 1) The relationship between social capital / social controls and suicide & anti-social behaviour (like violent crime). 2) The clustering of problems in communities (quoting Desjarlais et al 1995) such as *social pathologies* (substance abuse, violence, abuse of women and children), *exacerbating*	Focus is on demonstrated and proposed links between social capital and mental health. Concludes with six recommendations for further research (p 34).	

		conditions (unemployment, poverty, limited education, stressful work conditions, discrimination), and *health problems* (physical and mental). The identified fundamental causes are linked to resources like money, power, prestige and social connections. (They conclude however, that the links between social capital, mental health and health are unclear, and although social capital supports the ideals of a thriving community, it is difficult to trace how this relates to better health actions and status, including well-being & quality of life.) The social capital mechanisms for improving health & mental health are derived from Berkman & Kawachi (2000) a) SC may influence health related behaviours b) SC may improve access to services and amenities c) SC may enhance protective psychosocial processes Based on research in Rwanda and Cambodia, it is also postulated that good mental health is a mechanism for building social capital, enhancing more constructive participation in civil society, and assuming a more productive social role (p27). The report concludes with 6 recommendations for further research (p34) - Examine the interrelations of human capital and social capital, exploring the distinctions, dynamics, and relationships between the two - Sharpen the tools for measuring social capital, especially in relation to those social capital variables most pertinent to health and mental health analysis and research - Elaborate the links between health, mental health, and social capital by undertaking prospective longitudinal studies in both developed and developing countries - Analyse the links between mental health, violent conflict and social capital, by for instance examining the ways social capital may be able enhance mental health interventions and service delivery and mental health status through the networks, support and norms social capital provides - Examine how improvements in individual and population health and mental health might build social capital, and		

		quantify the economic benefits of this - Examine how social policy, including health policy, can be developed so as to promote the growth of social capital and mitigate against its erosion.		
Social capital & health. **Veenstra** G (2001) *Canadian Journal of Policy Research*; 2(1): 72-81.	A review of the literature which examines SES inequalities, social capital and health (see below).	Proposes that individual-level relationships have been explored in depth, but ecological and contextual effects are less well understood and require further empirical exploration and conceptualisation. A few studies are reported - - Kawachi et al (1997) provide evidence that trust and health are related at the ecological level (although individually held trust does not necessarily produce health for that individual). - Putman (2001) shows community level social capital influences degree of happiness. Distinguishes between social capital's: - *Compositional* effects, which are the intrinsic benefits that result from contributing to social capital ie the actions and ideals that individuals engage in or express may be health inducing in and of themselves. - *Contextual* effects, social capital within the civil space may influence performance of political institutions and other organisations (ie adherence to welfare principles and efforts to redress inequity, equity of access to services and amenities) and thus influence population health through indirect means.		
	Overview of the literature on the associations between social capital and crime, civil society and democracy, and public health – both morbidity and self-reported health.	There is growing evidence of the relationship between social capital and self-reported health and wellbeing. Proposed mechanisms linking social capital & health also distinguish between compositional and contextual effects: - *Compositional* effects of social capital (ie areas lacking social capital have more socially isolated individuals living there because such places provide fewer *opportunities* for individuals to *form local ties* – and social connectedness and social ties themselves lead to poor health outcomes) - *Contextual* effects of social capital on 3 potential pathways a) influencing health related behaviours by (i) promoting more rapid diffusion of health information and/or (ii) exerting social control over deviant health related behaviour b) influencing access to services and amenities as socially cohesive communities are better at uniting in political activism and organising to ensure adequate access to services		Valuable overview, but focus on psychological effects is only as an intervening variable to physical health

		c) affecting *psychosocial processes* by providing support and acting as a source of self-esteem and mutual respect (even socially isolated individuals living in socially cohesive communities appear to have better health status than socially isolated individuals in communities with low social capital) d) on a State level social capital appears to promote more egalitarian patterns of political participation, and greater responsiveness and smooth functioning of civic institutions, and more investment in welfare assistance as a percentage of per capita income (social capital measured as inter-personal trust).		

Table A.2.2: Social Capital – associations with mental health (empirical studies)

Publication	Aim or Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
Neighbourhood composition and depressive symptoms among older Mexican Americans. **Ostir** GV, Eschbach K, Markides KS, Goodwin JS (2003). *Journal of Epidemiology and Community Health*; 57: 987-992.	Examined association between depressive symptoms & 2 different aspects of neighbourhood composition (community-level measures): 1) % ethnic group concentration; & 2) % neighbourhood poverty.	This cross-sectional study in 5 south western states in the US found a strong correlation between the percentage of neighbourhood residents living in poverty (below the poverty line) and the percentage who were Mexican American. However, when neighbourhood composition measures were adjusted for each other - higher % of neighbourhood poverty was associated with higher levels of depressive symptoms. - higher % Mexican American was associated with lower levels of depressive symptoms. Concludes that higher ethnic group concentration in a community, and the associated strong social and family support structures may buffer some of the effects of low social and economic status on depressive symptoms.	Supports literature on the health benefits of strong social capital within local neighbourhoods.	
Social capital and sense of insecurity in the neighbourhood: a population-based multilevel analysis in Malmo, Sweden. **Lindstrom** M, Merlo J, Ostergren P (2003)	Tests the influence of two different measures of social capital: 1 social participation & 2 electoral participation on individuals' insecurity	In this cross-sectional study of 68 neighbourhoods, the first form of social capital (social participation) was measured at the individual level ie how actively the individual takes part in formal and informal activities in society. The second measure of social capital (electoral participation) was a contextual-level measure ie % electorate that participated in the 1994 municipal elections. Electoral participation in the neighbourhoods studied ranged from 54.5% to 97.7%. - There were significant neighbourhood differences in levels	Identifies correlation between community level measure of social capital and fear of crime and sense of insecurity in local neighbourhood (which in other studies has been identified as an	

Social Science & Medicine 56:1111-1120.	(after dark) related to crime in their neighbourhood.	of security/insecurity related to crime. After adjusting for a variety of individual factors (age, sex, country of origin, educational level) and even individual social participation (individual level measure of social capital) – neighbourhood differences in level of insecurity were unaltered. Thus individual level measure of social capital (social participation) was only marginally correlated with levels of insecurity. - When electoral participation was introduced into the multi-level model (contextual-level measure of social capital) the significant differences in sense of insecurity between neighbourhoods disappeared. Thus social capital operationalised at the contextual level as electoral participation was very strongly correlated with variations in levels of insecurity (explained 74% of variation between neighbourhoods in a model including all individual variables).	important source of psychosocial stress)	
Trust and distress in three generations of rural Australians. **Berry** HL, Rogers B (2003) *Australian Psychiatry* 11(Supplement 1): S131-S137.	Trials two different approaches to measuring trust, and elaborates on the relationship between trust and distress.	Builds on findings from **Berry** & Rickwood's paper (2000 – see below). A random sample of 969 members of a rural community completed an anonymous self-report postal questionnaire that includes two different measures of trust: the *Organisational Trust Inventory (OTI)*, and the *World Values Survey (WVS);* as well as a measure of *General Psychological Distress*. Premise identifies limitations in the WVS ie that it is too simplistic as a tool to measure the complex notion of trust. The OTI is proposed as a more comprehensive tool. - Older respondents reported fewer symptoms of distress and greater trust. - There were significant interactions between age and both of the trust scales ie the associations between trust and distress were not the same for all ages. - The OTI scale was found to be a more powerful predictor of distress than the WVS scale, and whatever the WVS scale measures is almost entirely also captured in the OTI scale.	Australian empirical study that examines correlation between trust and mental health	Focus is on individual-level measures of trust, rather than community-level measures of social capital
The relation of social capital to child psychosocial adjustment difficulties: the role of positive parenting and neighbourhood	Examines 3 pathways through which social capital may relate to fewer child psychological adjustment difficulties: - directly	*(Abstract only available at time of reporting)* Study of 130 African American mothers and their children (7-15yrs) living in inner city New Orleans. Results indicate social capital impacts on child psychological adjustment difficulties through its relation to positive parenting and		

dangerousness. **Shannon** D, Rex F (2003). *Journal of Psychopathology & Behavioral Assessment;* 25(1): 11-23.	- through relation to positive parenting - through relation to neighbourhood dangerousness	neighbourhood dangerousness, but there was no independent direct effect.		
Social capital for health; investigating the links between social capital and health using the British Household Panel Survey. **Pevalin** DJ, Rose D (2002) (NHS) Health Development Agency http://www.hda-online.org.uk/documents/socialcapital_BHP_survey.pdf	Examines relationship between SES (labelled 'structural factors') and social capital (individual-level measures) and health (including common mental illness).	Cross-sectional and longitudinal analysis of British Household Survey data. Relies on 4 different (individual-level) measures of social capital - social participation (organisations etc) - social contacts (friends) - perceptions of crime in neighbourhood, and - level of attachment to neighbourhood This is a detailed report with multiple levels of analysis and findings. Overall findings are: - Structural factors (ie age, sex, marital status, income, employment, education etc) impact on mental and physical health as well as the individual's level of social capital. - Study also found that the individual-level measures of social capital had positive effects on mental and physical health, but did not mediate the effects of the basic 'structural factors' on health. - An exception was the effect of social participation which moderated the effect of working status on health for working age women. - Predicts that developing individual social capital may produce some benefits for health, but will do little to negate the more fundamental inequities in health due to 'structural factors'.		
Intra-household differences in neighbourhood attachment and their associations with health. An analysis of the British Household Panel Survey.	Describes relationship between individual / household 'neighbourhood attachment' & common mental illness, physical health, divorce & moving residence.	- Individual-level low neighbourhood attachment associated with higher risks of common mental illness and poorer self-related health (latter association weaker). - Household-level differences in neighbourhood attachment resulted in higher risks of common mental illness in men if lower attachment. If both spouses had lower levels of attachment, risk of mental illness increased for both men and women. No effects on self-related health.	Focuses on common mental illness	UK based study, generalisability unknown.

Pevalin D (2002) Conference paper at Social Action for Health and Wellbeing, Health Development Agency, London, June 21-22		- Lower attachment in women (not men) or in both spouses also associated with higher risk of separation or divorce. - Lower level of attachment in one spouse doubled likelihood of moving residence and quadrupled if both spouses had low attachment.		
The Social Capital Community Benchmark Survey. (2001) **Saguaro Seminar**; Civic Engagement in America, John F. Kennedy School of Government, Harvard University. Website: http://www.ksg.harvard.edu/saguaro/communitysurvey/	Base line surveys to assess how connected Americans are to each other. Also to assess correlations of social capital with community descriptors and reported wellbeing.	A project of three dozen community foundations, Harvard University (the Saguaro Seminar of the John F. Kennedy School of Government) and other funders. Survey asked 10 questions relating to social connectedness of nearly 30,000 people. Measures of social connectedness were strongly correlated to measures of quality of life and personal happiness (more than income or education). Executive summary of the findings is available online.	Described as the largest-ever survey on the civic engagement of Americans.	Generalisability of findings is questionable.
Social Capital; measurement and consequences. **Putnam** R (2001) *Canadian Journal of Policy Research*; 2(1): 41-51.	A summary of his research on the sharp decline since the 1960s in all measures of social capital in the US, & its correlations (with factors like educational performance, crime, welfare and health; and civic and economic equality.)	- His results confirm multiple prospective studies that show social connectedness dramatically reduces mortality. - Presents his own new findings that social capital has a strong correlation with individual self-assessments of welfare and happiness. - Happiness increases with both an individual's own and their state's measure of social capital. (In contrast, an individual's measure of happiness rises if their own income is higher, but falls when the average state income is higher.) - Putnam postulates that because community levels of human and social capital increase happiness, while higher average community income appears to reduce happiness, the returns from human and social capital are much broader than the positive effects they may have on material standards of living. - Tolerance, civic and economic equality are also strongly correlated with social capital.	Provides new data on social capital & mental wellbeing	Research conducted in US only, generalisability unknown.

Health, inequities, community and social capital. **Bush** R; Baum F (2001) In: Eckersley R; Dixon J, Douglas B. The Social Origins of Health and Well-being. Cambridge University Press, Melbourne.	Chapter includes report on the Adelaide Health Development and Social Capital Study (paper below), preceded by overview of theoretical/historical underpinnings of social capital.	Survey results in Baum et al (2000) below. In their findings social participation was correlated with health status but not with a sense of community control; while civic participation was associated with sense of community control but not with health status.		
Epidemiology of participation: an Australian community study. **Baum** F, Bush R, Modra C, Murray C, Cox E, Alexander K, Potter R. (2000) *Journal of Epidemiology and Community Health*; 54(6): 414-423.	To determine levels of participation in social & civic community life; and assess differential levels according to demographic, socioeconomic and heath status.	- Study highlighted relative lack of involvement of people with low income and educational level in social and civic activities. - Although the survey could not identify the causal direction of participation, SES and health, authors note that determinants of health advantage are those also associated with higher social and civic participation ie like health, degrees of civic and social participation are socially & economically structured. - Mental health status was more strongly correlated with social participation than physical health. - The study was not able to provide explanations why the observed patterns of distribution in participation rates exist. The Adelaide Health Development and Social Capital Study examined the levels of participation in *social* activities and *civic* activities (individual or collective) through a mailed questionnaire - random sample in western suburbs of Adelaide (2,542 responded from initial sample of 4,000). Reasons for participation were examined through in-depth interviews, and community groups and organisations were surveyed to examine the role they played/potential to play in promoting health. Survey revealed that people are most likely to participate in informal social activity (83% visit family, 46% visit neighbours) and least likely to participate in collective civic activity (<6%). People with higher levels of household income are more likely		

		to participate in individual or collective civic activities and social activities outside their home. A similar, but more significant pattern was found for level of educational attainment. (Authors note participation is not a substitute for policy measures to reduce material disadvantage, and reducing inequities itself is likely to be one of the most effective means of encouraging broader civic participation).		
Measuring social capital at the individual level: personal social capital, values and psychological distress. **Berry** HL, Rickwood DJ (2000) *International Journal of Mental Health Promotion* 2(3); 35-44.	Examine whether 'personal social capital' is a predictor of psychological distress.	Examines the correlation between individual-level measures of social capital (ie community participation, social support & trust in others) and measures of psychological distress. - Study found that those who participate more, have more social support, and show greater trust in others experience less psychological distress. The strongest predictor of distress was community trust (trust in people generally ie unfamiliar others, rather than trust in family or friends). - Propose that individual connectedness to the community primarily influences mental health indirectly through the concept of trust.	Focuses on psychological distress as an outcome	Focuses on individual-level measures of social capital rather that as a societal-level construct.
How much does social capital add to individual health? A survey study of Russians. **Rose** R (2000) *Social Science & Medicine*; 51: 1421-1435.	Examines the extent to which variations in physical and emotional health are affected by human and social capital in a Russian population	- Social capital (all dimensions combined) was correlated with self reported levels of emotional and physical health. (Explained 15.7% of variance in emotional health and 16% for physical health.) - Social capital and human capital (education, gender, age, income, social status) combined explained 19.3% variance in emotional health and 22.9% for physical health. - Not all dimensions of social capital were significant however, ie social integration measured by perceived 'control over own life' was the most significant, followed by having 'someone to rely on if ill', and believing that 'most people could be trusted'. All other indicators of social integration however, eg belonging to various organisations had no effect on emotional or physical health (in Russia this measure of social capital is consistently low across the population).		
Giving means receiving: the protective effect of social capital on binge drinking on college	Examine whether higher levels of social capital on college campuses protected against individual risks	N = 17,592 young people enrolled in 140 colleges. 43% respondents reported binge drinking (more likely to be male, under 24, college educated parents and identify as White). - Individual volunteerism was associated with 5% reduction in risk for binge drinking.	Examines potentially protective effect of social capital on unhealthy behaviours (which may or may not	Outcome variable binge drinking rather than mental health or wellbeing.

campuses. **Weitzman** ER, Kawachi I (2000) *American Journal of Public Health*; 90(12): 1936-1939.	of binge drinking. Social capital was operationalised as individuals' average time committed to volunteering in the past month – aggregated to campus level.	- When social capital (campus-level volunteerism) was added to the analysis, students at campuses with high levels of social capital were 26% less likely to binge drink than peers at campuses with low levels of social capital. Results remained constant after adjusting for all potential confounders. - Social capital was positively correlated with low-risk drinking ie 1 to 2 drinks only. - Speculate the protective effect may be as a result of norms and social controls curtailing deviant behaviour and dangerous consumption where individuals are more bonded with each other and the group, or use of alcohol is higher in communities with high stress and low social capital.	be mediated by stress)	

Table A.3.1: Social Capital – Intervention options

Publication	Aim or Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
The CommunityLIFE project. Website: http://www.community-life.org.au/nsps.php	Aims to support groups in the community to develop suicide prevention activities and programs.	The project is based on the LIFE Framework, the national framework for suicide prevention activities in Australia. This includes four broad goals: 1 Reduce deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, suicidal behaviour, and the injury and self-harm that result. 2 Enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide. 3 Increase support available to individuals, families and communities affected by suicide or suicidal behaviours. 4 To provide a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes. *"Effective action requires the involvement and cooperation of the whole Australian community, to work together to build resilience, resourcefulness tolerance and capacity in communities and in people of all ages"*	Identifies Australian projects - provides a listing of all projects (+ contact details) funded under the National Suicide Prevention Strategy. Many projects adopt strategies that address aspects of social capital	Focus is not specifically on social capital.
Community-based intervention. **McLeroy** K, Norton B, Kegler M, Burdine J,	Model – an editorial to clarify distinctions between different types of community-	Presents a typology of community-based intervention of four categories: 1) Community as the setting for intervention (focus of these interventions tends to be on changing individuals' behaviours	Excellent model to differentiate between approaches (and possible evaluation	Mental health not specifically addressed

Ciro S. (2003) *American Journal of Public Health*; 93(4): 529-533.	based interventions. Also examines the importance of community capacity and civil society; the use of social ecology as a framework.	as a method for reducing the population's risk of disease; thus although the target of change is the population, the population change is defined as the aggregate of individual change). 2) Community as the target of change (goal is creating healthy community environments through systemic changes in public policy or community wide institutions, with community changes as the desired outcomes). 3) Community as resource for intervention (based on principle that community ownership and participation is essential for sustained success of population-level health outcomes; yet involve some external resources / actors to initiate and coordinate activities. 4) Community as agent (linked to (3) but emphasis is on respective and reinforcing the natural adaptive, supportive and developmental capacities of communities – which often meet the needs of community members without professional intervention. Civil society described as the self-organising activities of people within associations, unions, churches, and communities (thus not the state or the market). Civil society is the "setting of settings" in that vital CS provides an essential context for successful community based health promotion. Social ecology highlights that interventions may occur at one level and produce change at others, and thus need to distinguish between *levels* of intervention and *targets* of intervention.	measures) when planning community interventions. Directly relevant to programs aimed at strengthening social connectedness, civil society, and social capital.	
Social Capital; a discussion paper. **Aldridge** S, Halpern D, Fitzpatrick S (2002) Cabinet Office Performance and Innovation Unit, London. Website: http://www.number-10.gov.uk/su/social%20capital/socialcapital.pdf	Aims to facilitate debate on policy implications and potential initiatives (Not statement of government policy)	Summary of existing UK policies that are given extra weight by social capital literature; and proposes some potential new initiatives on Individual, Community and National levels for stimulating social capital – with details and examples (p56-73). - Individual (greater support for families and parenting, mentoring, new approaches to dealing with offenders, volunteering). - Community (promoting institutions that foster community, community information & communications technology, new	Good ideas for interventions and programs that could be adapted for local settings	

		approaches to planning and design of built environment, dispersing social housing, using personal networks to pull individuals and communities out of poverty, various other) - National (service learning, community service credit schemes, facilitating mutual respect)		
Exploring social capital and civic engagement to create a framework for community building. **Hyman** JB (2002) *Applied Developmental Science*; 6(4):196-202	Model - presents a framework of the 5 components of the community building (CB) process. One aim is to improve the degree to which CB is replicable as an intervention strategy.	Community building components: resident engagement; agenda building; community organising; community action; communications and message development. (read abstract only)		
*Better Together: report of the **Saguaro Seminar** on Civic Engagement in America.* (2000, revised 2002) John F. Kennedy School of Government, Harvard University (Cambridge, MA) See website: http://www.bettertogether.org/aboutthereport.htm	Recommendations - Sanguaro Seminar is composed of around 3 dozen leaders of institutions who meet several times a year to debate proposals for reinvigorating civic life (director Robert **Putnam**).	Report includes recommendations in five chapters organised around institutional arenas in which social capital can be built: the workplace; the Arts; Politics and Government; Religion; Schools, Youth Organisations, and Families. Each chapter presents historical trends relevant to building social capital, guiding principles and specific recommendations, and case studies of initiatives and interventions.	Great source of ideas for intervention programs and projects.	US based project, some ideas may not be readily transferable without adaptation.
Goodna Service Integration Project & other social capital initiatives from University of Queensland Community Service & Research Centre http://www.uq.edu.au/csrc/socialcapitalprojects.php	Project overview identifies the aim to develop a sustainable system of human service provision.	Government funded project from 2000 – March 2003. Project objectives: - aligning strategies of government agencies to community needs & Government priorities - building social capital - facilitating integration of human services - delivering community wellbeing outcomes Identify 4 policy statements/recommendations: - *Government services are most efficiently and effectively delivered when there is maximum alignment between*		

		community's needs and aspirations, government's priority outcomes and agency service delivery strategies. *- Activities that promote engaged service integration are also likely to build social and network capital and improve community well-being* *- The foundations of effective management, collaboration and resource allocation in response to complex issues are relationship building, learning and outcome measurement and modelling. The Ministerial Regional Community Forums and* *- Regional Managers of Government Forums play essential roles in facilitating community engagement and regional collaboration.*		
The interrelations of social capital with health and mental health; discussion paper. **Cullen** M, Whiteford H (2001) National Mental Health Strategy, Commonwealth of Australia.	Overview of literature & informed by the outcomes of a 'social capital and mental health workshop' held at the World Bank in Washington DC, July 2000.	Suggestions from workshop: interventions to build social capital at the community level may include (p13): - *strengthening social networks* eg a community health worker who mobilises resources within social networks as well a brings resources into communities - *building social organisations* eg NGOs - *strengthening community ties* ie bridging groups normally divided along class, caste, race/ethnicity, religious grounds - *strengthening civil society* eg informing decision makers about the social consequences of macro-economic policies.		
Making the links between community structure and individual well-being: community quality of life in Riverdale, Toronto, Canada. **Raphael** D, Renwick R, Brown I, Steinmetz B, Sehdev H, Phillips S (2001) *Health & Place*; 7:179-196.	Identifies aspects of the community that its members perceive to determine local quality of life & wellbeing.	Presents a 'Riverdale community quality of life model' to identify (on macro, meso, and micro levels) the key elements (supports and barriers) perceived to contribute to quality of life and wellbeing. Model is based on findings from focus groups and key informant interviews with community members, service providers, elected representatives. - Model includes aspects of the following: 1) Federal & provincial social policy 2) Municipal support of community infrastructure 3) Responsive community institutions 4) Citizen coalitions and groups 5) Community members (including neighbourliness, political orientation & sophistication, support of local institutions) - In relation to social capital literature the authors note that support from neighbours and institutions was perceived as an	The study was not specifically examining social capital, but authors link their findings to aspects of the social capital literature.	

		important determinant of quality of life. They also report virtual unanimity about the importance of community resources (community centres, service agencies, churches etc) for providing the means for *developing* and *maintaining* social connections. - Much of what passes as social capital in Riverdale is supported by structures funded by governments. Institutional and non-institutional networks, community members advocacy, and political activities were all initially supported by community agencies and institutions (reinforces the concept of *vertical* associations, where political institutions support community structures that enable norms of reciprocity to develop).		
Building social capital with a refugee community – a case study of partnership. **Tomlinson** K, Lee S (2001). *Synergy* (newsletter) The Association for Services & Trauma Survivors, WA. http://www.mmha.org.au/MMHAPublications/Synergy/SpringSummer%202001/BuildingSocialCapitalinRefugeeComms/view	Descriptive case study of a community development project from the *Synergy* newsletter that set out to build social capital among a group of refugees in WA	Project targeted a newly arriving refugee group who had no sense of community among themselves and no sense of belonging to the existing Australian community. - Group request and obtain a community centre, but the venture fails due to lack of use by local community due to inadequate group ties to bring them together. Community radio initiative is more successful. After 2 years there are the beginnings of early indications of developing social capital within the community.	Intervention specifically aimed at building social capital	No recorded evaluation – case study in the form of reflections by project staff

Table A.3.2: Social Capital and mental health – Intervention options

Publication	Aim or Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
'More community!' Does the social capital hypothesis offer hope for untrusting	Examine empirical predictors of 3 types of trust (data from the Middle Australia	- The personal trust we have in neighbours, the general trust we have in others, and our trust in governments are different, have different predicting variables, and if damaged have different consequences and require different remedies.	Empirical study using Australian data – highly relevant	Focus is on trust as an outcome – direct link with mental health not examined.

societies? **Fattore** T, Turnbull N, Wilson S (2003) *The Drawing Board: An Australian Review of Public Affairs*. School of Economics, University of Sydney.	Project) - in neighbours - trust in others - trust in government Challenge idea that straightforward 'more community' solutions will be effective in building greater trust.	- Authors propose that associational life is not automatically virtuous as group activities may 'bond' together and assist the winners in society, rather than create 'bridges' for the losers (Jowell, 2003). - Community *belongingness* scale best explained *personal trust in neighbours* (but more associational membership did not predict higher trust in neighbours. Thus multiple group membership did not translate into more trust, as social capital models may predict) - Confidence in *public institutions* and holding positive attitudes towards *welfare* best explained *general trust in others* (social capital scales ie community belongingness and associational membership did not explain this type of general trust in others). Infer that generalised trust in others is connected to our confidence in the intentions and activities of strangers and institutions. - Confidence in *public institutions* and a *benign* class *worldview* (ie perceptions about the distribution of economic power) best explained *trust in government*. (The more people perceive the world as economically and unfairly unequal, the less likely they trust in governments. The social capital scales of community belongingness and associational membership did not explain trust in government) Conclude that the mechanisms that determine trust in impersonal relationships (general trust in others or governments) do not in the first instance derive from our associations or our community life (social capital). - People differentiate between their local/intimate spheres, and the broader world of impersonal action and forces. Trust in institutions and in strangers is a 'highly mediate experience' and not consonant with our immediate sphere of influence. p172-3 - Community building intervention options often call for 'more community' ie encouraging participation through associational membership, opportunities for input into decisions, and greater community consultation. Authors challenge the idea that building up community associations and community life alone will solve the ills of an untrusting society.		

		Thus cause-effect in social capital-social benefit hypothesis could be reversed (or at least 2-way) ie solution is not 'more community' but more social resources (opportunities, income, education, which in turn make people more willing and able to participate in & trust their communities).		
Social capital, social exclusion and ethnic health inequalities. **Campbell** C, McLean C (2002) Conference paper at Social Action for Health and Wellbeing, Health Development Agency, London, June 21-22	Studies among African-Caribbean (A-C) residents deprived multi-ethnic area of south England town. 1) relationship between ethnicity & social capital 2) likelihood of A-C participation in local initiatives to improve mental health	1) A lack unity at community level was perceived by participants as a disadvantage that increased social exclusion and limited access to community resources. – African-Caribbean identity played central role in peoples' participation in inter-personal networks, but participation levels in voluntary organisations and community activist networks were very low. A context of institutionalised racism resulted in people unlikely to view local community networks as representing their interests. 2) Identified severe obstacles to implementing principle of community participation in local initiatives to improve mental health ie distrust between sectors, disillusionment of lay people, lack of community capacity, inadequate resources. Conclude policies that simply call for increased community participation but do not fund and implement measures to remove the obstacles may be 'set up to fail'.		

Table A.4: Social Capital – Intervention evaluations

Publication	Research Question Design	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
The Beacon Project, Cornwall, UK. Cited in: **Duggan** M (2002) *Modernising the social model in Mental Health: a discussion paper.* Social Perspectives Network (SPN) for Modern Mental Health.	Example of a widely acclaimed community development project - focused on improving social conditions and enhancing social capital (although not labelled as social capital). More info in 2 online reports:	Uncontrolled evaluation - but before and after statistics available in online reports eg between 1995-1999: - Overall crime rate dropped by 50% - Child Protection Registrations dropped by 42% - Post Natal Depression down 70% - Children's educational attainment up 100% - Reduced number of unwanted teenage pregnancies - Unemployment rate down 71% [male and female]	Case study of a successful multifactorial social and economic initiative that had a significant impact on depression rates.	

spn@topssengland.org.uk	http://www.sensorytrust.org.uk/news/newsletters/newsletter_3/beacon.html http://www.guardian.co.uk/guardiansociety/story/0,3605,397300,00.html			
Claymore Community Employment Cooperative. Profiled on ACCORD website (Australian Centre for Cooperative Research and Development) http://www.accord.org.au/social/profiles/claymore.html Success of local community development initiatives in Claymore also described in *Resilience* by Ann Deveson, 2003.	Aim to create employment opportunities for residents in the areas of greatest need; housing maintenance; and beautification of the estate. Claymore community is a highly cited Australian example of successful community regeneration & development.	- Thirty residents employed directly by the Claymore Employment Co-operative. - A further thirty residents will have participated in training leading to employment not related to the co-operative. - Five micro/small businesses established and managed by residents. - Community Park Developed. Much of the training will initially be focused on horticulture, garden and building maintenance, catering and leadership skills. The Community Park will provide a practical component through which these skills can be learnt and practiced. In addition, the Community Park (which is seeking funds through the Macarthur Area Assistance Scheme) will employ services from the co-operative as a first option. - Vocational Education Twenty residents will have competed Certificate II Horticulture (Parks and Gardens); Fifteen residents will have completed Certificate IV Small Business Enterprise Management; Sixteen residents will have completed Certificate II in Hospitality and Catering. - Leadership Twenty residents will have undertaken leadership skills development workshops; Thirty residents will have been supported to gain the skills needed to manage the Claymore Employment Co-operative (these skills will be readily transportable to other community projects and leadership roles). - The CECP will further develop the objectives of the Stronger Families and Communities Strategy in a number of ways.		

TABLE B – SOCIAL NETWORKS

Table B.2 Social Networks - associations with mental health (reviews and summaries)

Table B.4 Social Networks – intervention evaluations (reviews and summaries)

Table B.2: Social Networks – associations with mental health (reviews)

Publication	Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
Social ties and mental health. **Kawachi** I & Berkman LF (2001) *Journal of Urban Health:* 78(3): 458-467.	Targeted review highlighting key insights from the literature.	There is wide agreement that research to date has demonstrated that social ties have a beneficial effect on mental health outcomes (stress reactions, psychological wellbeing, and symptoms of psychological distress including depressive symptoms and anxiety). This review draws attention to three insights from the available literature on the relationships between social ties and mental health. See table below (B.4) for issues regarding interventions (Kawachi & Berkman, 2001). 1) Two different, but possibly complementary, mechanisms have been proposed to explain how social relationships influence mental health: - *main effect* model (ie social networks have a beneficial effect regardless whether individuals are under stress) - *stress buffering* model (ie social networks improve wellbeing for those under stress). It is also proposed that the *structural* aspects of social ties (eg social networks and social integration) have a direct effect on well being regardless of stressful circumstances, while the *functional* aspects (eg perceived support) operate by buffering the effects of stress. 2) The costs and benefits of social ties are not randomly distributed in the population, but rather are systematically modified by gender, socioeconomic position, and stage in life. 3) Although most studies of social ties have been conducted	Useful overview that draws together key insights from the relevant literature	

		from an egocentric perspective (ie individual level), social networks and social support are embedded in 'macrosocial exchanges'. Propose that one of the key insights from social capital theory is that individual's egocentric ties maybe contingent on the structural characteristics of social networks (eg density of civic associations or extent of voluntarism in a community). Empirical investigations need to *demonstrate the contextual influence of social capital on individual networks and support and on individual mental health outcomes.*		
Social integration, social networks, social support & health. **Berkman** LF & Glass T (2000) In: Berkman LF, Kawachi I *Social Epidemiology*. New York; Oxford University Press	Overview of available research.	- Epidemiological research from the 1970s / 80s demonstrated the strong associations between social networks (social ties, social connectedness, integration, activity, embeddedness) and almost every cause of death. - Research from 1980s / 90s shifted focus on social networks as a source of *social support* and demonstrated the positive impact of social support on health. These studies also demonstrated the importance of a life-course perspective on the relationship between social support and health ie social support and social connectedness during key periods of development have a long term impact on psychosocial wellbeing. - Until the 1990s, the rather narrow focus on (1) social support was at the exclusion of the other functions that are also provided by social networks. The other *psychosocial* mechanisms between social networks and health have since been examined in more detail eg social networks are also an source of (2) social influence (3) opportunity for social engagement & thus meaningful roles (4) resources and material goods (5) intimate one-on-one contact that can impact on health via the transfer of infectious agents, as well as providing emotional support and companionships. - Research indicates that the mechanisms (1-5) work along 3 pathways: a) influencing health *behaviours* b) on *psychological pathways* by influencing *self-efficacy, self-esteem, coping effectiveness, depression and distress*	Berkman and Glass (2000) combine the different studies on the relationship between social networks and health into one overarching framework. A key feature of their model is the way **mental health** forms a core and integral component of the relationship between **social relationships** and **health** ie physical and mental health are examined in a holistic and integrated fashion. The model is also explicitly places the nature and impact of social networks on health within their upstream **context,** which is categorised into: - culture - socioeconomic factors	

		and sense of wellbeing, and c) directly impacting on physical health along physiologic pathways. Available *measures* of social relationships are identified on page 156 - social relations (social ties, social integration) - social networks - social support (perceived and received)	- politics, and - social changes.	
The age of anxiety? Birth cohort change in anxiety and neuroticism, 1952 – 1993. **Twenge** JM (2000) *Journal of Personality and Social Psychology* 79(6): 1007-1021.	Study combines four decades of US data on student self-reported anxiety and examines correlations with social indices.	Results indicate that US college students and US school students self-reported levels of anxiety have significantly increased over time. The increase in anxiety scores in both groups increased in a linear fashion, rising by 1 standard deviation between 1950s to the 1990s, explaining ~ 20% of the variance. - The increases in anxiety scores were correlated with low social connectedness and low perceived safety (high perceived environmental threats eg crime). - Economic conditions did not explain the rise in anxiety scores when controlled for the other two influences, in college students (with less diversity in SES) or school students (high diversity in SES). - Anxiety scores have risen to such a degree that the scores from normal samples of children collected in the 1980s where higher than the anxiety scores collected from psychiatric populations in the 1950s.	Demonstrates increased anxiety and possible correlations – causality postulated only.	US data, potential biases and confounding are identified
Health promoting effects of friends and family on health outcomes in older adults. **Seeman** TE (2000) American Journal of Health Promotion 14(6): 362-70.	Review of literature between 1970-1998 on social relationships and health among older adults.	Social relationships have potentially health promoting and health damaging effects. Positive mental and physical health effects are associated with social interactions among older adults, including better recovery after disease onset. Negative effects from social interactions arise from critical and/or overly demanding social ties, and are correlated with elevated stress hormones and increased risk of depression and angina.		

Table B.4: Social Networks – intervention evaluations (reviews)

Publication	Research Question	Content / Findings & Conclusions	Strengths (in relation to VicHealth project)	Limitations (in relation to VicHealth project)
Parent-training programs for improving maternal psychosocial health. **Barlow** J, Coren E (May 2002 - last update) *Cochrane Database of Systematic Reviews.* 1, 2003.	Systematic review of group parenting programs to determine whether they are effective in improving maternal anxiety, depression and self-esteem.	Available intervention evaluations suggest that parenting programs can make a significant contribution to the short-term psychological health of mothers. There is insufficient research however on whether these positive benefits are maintained over time, and the limited follow-up data that are available show equivocal results. - Need research into the long-term effectiveness of parenting programs on maternal mental health. - Also need to identify which factors / aspects of these interventions contribute to the successful outcomes that have been demonstrated (eg it may be the social networks that participants gain and the support they give each other).	Rigorous review of simple intervention	Individually targeted interventions (small groups) – not focused on broader social support networks.
Home-based social support for socially disadvantaged mothers. **Hodnett** ED, Roberts I (Aug 2001 – last update) *Cochrane Database of Systematic Reviews.* 1, 2003.	Systematic review of programs offering additional home-based social support to socially disadvantaged mothers. *Note - review withdrawn in 2001 pending update by new authors.*	- Postnatal follow-up programs of mothers and babies offering home based social support with continuity of caregiver may have important benefits for socially disadvantaged mothers and their children. - Programs that make use of the skills of experienced mothers living in the communities may be less expensive and more culturally sensitive than purely hospital-based programs led by teams of health care professionals. *Authors note results to be viewed with caution as 7 of the 15 trials were awaiting further assessment.*		
Social ties and mental health. **Kawachi** I & Berkman LF (2001) *Journal of Urban Health:* 78(3): 458-467.	Targeted review highlighting key insights from the literature.	- Conclude that two decades of intervention research have demonstrated the feasibility of manipulating and enhancing social support, but there is less evidence about the effectiveness of such interventions as a means of improving mental health. - Some successes have been described in the literature (eg support group interventions; one-to-one support interventions; interventions to enhance natural networks). However, significant variations in the design, duration, timing, and type of social support intervention studies mean that few generalisable lessons can be gleaned.	Brief overview of key issues – accessible and relevant	

		Research is needed to identify: - mechanisms by which social network interventions improve health outcomes; - characteristics of those who benefit most (and least) from social network interventions; and - nature of the 'dose-response' relationship between social ties and mental health (and whether there is a *gradient* of benefit or a *threshold* effect); - There is also a need to compare interventions that strengthen existing networks with those that enhance and build new networks.		
Caregiver support for postpartum depression. **Ray** KL, Hodnett ED (May 2001 – last update) *Cochrane Database of Systematic Reviews.* 1, 2003.	Systematic review to assess the effect of professional and/or social support interventions for the *treatment* of postpartum depression	Examined two studies involving 137 women. Conclude that there is some indication that professional and/or social support may help in the treatment of postpartum depression. However what types of support are most effective still needs further investigation.		Intervention is focused on treatment of existing depression rather than prevention.
Support for women / families after perinatal death. **Chambers** HM, Chan FY (Nov 2001 – last update) *Cochrane Database of Systematic Reviews.* 1, 2003.	To consider the effectiveness of any form of medical, nursing, social or psychological support and/or counselling to mothers and families after perinatal death.	No suitable randomised trials were found to indicate whether or not psychological support or counselling after perinatal death is effective.	Rigorous review of simple intervention	Individually targeted clinical rather than social interventions. Only considered RCTs and no appropriate evidence found.
Mental health promotion in high risk groups. **NHS Centre for Reviews and Dissemination** (1997). Effective Healthcare Bulletin 3(3).	Review of interventions aimed at children or adults identified as high risk of mental health problems such as poor self-esteem, anxiety and depression, with the aim of preventing deterioration of mental health.	High risk children identified: living in poverty, exhibiting behavioural difficulties, experiencing parental separation and divorce, within families experiencing bereavement. High risk adults identified: undergoing divorce or separation, unemployed, at risk of depression in pregnancy, experiencing bereavement, long term carers of highly dependent people. Various effective social support interventions are described, however they all tend to be programs that are provided by health care or social service professionals on a small-group or one-to-one basis.		

		Effective interventions targeting children living in poverty and unemployed adults are described in table C.4 below.		
Preventive health promotion and support system interventions. Community Preventive Services Task Force (pending) http://www.thecommunityguide.org/mental/default.htm	Pending systematic reviews 1) Self-help/mutual support groups 2) Family support/ parenting skills Website identifies anticipated completion in early 2004.	Results not available at time of review		

TABLE C – SOCIO-ECONOMIC STATUS AND INEQUALITY

Table C.1: SES and Inequalities in mental health – concept definitions

Publication	Aim	Conceptual points	Comments
Social inequalities in mental health: a review of concepts and underlying assumptions. **Muntaner** C, Eaton WW, Diala CC (2000) *Health*: 4(1): 89-113.	Theoretical and explanatory overview of the literature	- Defines 'social inequalities' as a general term that encompasses both 'social stratification' and 'social class' (equivalent to our terms: *Inequalities* and *SES*). - Mental health defined as a set of outcomes that include psychiatric disorders (ie mood disorders, anxiety disorders, substance abuse and dependence disorders) and health events associated with these (ie suicide and homicide). Schizophrenia has been a common outcome measure in past research into social inequalities and mental health, but the diagnosis is unreliable when using survey methods (rather than clinical assessment). - There are at least 3 generations of studies that have demonstrated a correlation between social class and social stratification and rates of mental health / psychiatric disorders. - The US (as other developed countries) has experienced a 'polarisation of its economic structure' and in the last two decades there has been a surge of research into health inequalities.	

		Surprisingly, this has not been accompanied by a similar growth in psychiatric epidemiology or research into the sociology of mental illness.	
Underemployment and depression: longitudinal relationships. **Dooley** D., Prause J, Ham-Rowbottom KA (2000). J Health Soc Behav; 41: 421-436.	Unemployment underemployment inadequate employment	- conceptualises employment status not as a dichotomous variable, but a continuum ranging from adequate employment to inadequate employment to unemployment - unemployment: the status of people not working but wanting to work, including both those actively seeking work and those too discouraged to seek it - underemployment: various adverse employment statuses from unemployment to part-time and poverty wage employment - inadequate employment: refers to two specific types of underemployment, low-wage and involuntary part-time work	

Table C.2.1: SES and Inequalities – association with mental health (reviews and summaries)

Publication	Aim or Research Question	Content / Findings & Conclusions	Comments
A glossary for health inequalities. **Kawachi** I, Subramanian SV, Almeida-Filho N (2002) *Journal of Epidemiology & Community Health*; 56(9): 647-652	Summary of current research and outstanding debates on the study of health inequities	Their premise is that identification of health inequities (as opposed in describing inequalities) relies on normative judgements – which depend on one's theories of justice and society, and one's reasoning on the genesis of health inequalities - thus science alone cannot determine which inequalities are inequitable or which proportion is unjust or unfair. Although there is strong evidence and universal agreement that health inequalities exist, there is debate on what drives health inequalities - The *absolute income* hypothesis states that individual's health depends on their own (and only their own) level of income - The *relative income* hypothesis asserts that health depends not only on one's own level of income, but also on the relative incomes of others in society.	- Mental health is not the primary focus, but rather as an intervening variable between SES inequalities and health.

		(For any given level of income, health status depends on the rank within the income distribution that is bestowed upon the individual by their level of income- and the distance between their income and the average income (or other benchmarks of social comparison) Material depravation and **psychosocial** mechanisms explain health inequalities - *material* interpretation of health inequalities emphasises the graded relation between socioeconomic position and access to tangible material conditions such as food, shelter, access to services and amenities, car and home ownership, telephones, internet etc. - *psychosocial* interpretation ascribes health inequalities to direct effects (ie allostatic load on physiological system) or indirect effects (ie leading to an adverse profile of behaviours such as smoking and drinking) of **stress** – which stem from being lower on the socioeconomic hierarchy, or living conditions of relative socioeconomic disadvantage (Wilkinson 1997). There has been ongoing debate in the literature whether in developed countries absolute income levels and material standards of living are as important as relative income levels and psychosocial effects. - Lynch et al (2000) argue that absolute income levels are equally as important (if not more important) than relative income – a *'neo-material*' basis for reducing health inequalities. They also accuse those promoting a psychosocial hypothesis of health inequalities of disconnecting the psychological (ie worthlessness, distrust, breakdown of social relations) from the material – and undervaluing the impact of concrete factors such as not having access to a car or public transport and inadequate material living conditions. - Conversely, Wilkinson (2000) argues that once income meets basic requirements and is above poverty levels, disparities in income, social position, and their psychosocial effects have a greater impact on health that absolute income levels. This review, Kawachi et al emphasise that the material and psychosocial explanations of health inequalities are *not mutually*	

		exclusive and it is not usually possible to disentangle their effects. *All material resources of relevance to daily life have some psychosocial meaning attached* – eg employment and money provides for basic needs, as well as fostering a sense of control and self esteem. Determining which mechanism is more important is not that helpful if the *solution in both instances is to improve people's access to tangible resources*.	
Socioeconomic status and health in Australia. **Turrell** G, Mathers CD (2002) *MJA*;172: 434-438.	Overview of evidence in Australia for relationships between SES and health (physical and mental)	- evidence largely addresses physical health outcomes, but in terms of mental health, evidence shows that: - children and adolescents from disadvantaged backgrounds more likely to experience behaviour disturbance and social problems; and - young adults (15-24 yrs) of low SES have increased rate of death due to suicide	
Social capital & health. **Veenstra** G (2001) *Canadian Journal of Policy Research*; 2(1): 72-81.	A review of the literature which has interpreted the ecological relationships between income inequality & population health status. Review also examines SES and social capital (see below).	Key points on associations between SES inequalities & health: <u>Income & health</u> - SES relationship explained by purchasing power (income), knowledge power (education) and employment power (prestige & control) as resources that elevate or sustain health status. - Relationship on individual level, *within* Western nations, is curvilinear with a smooth (but weakening) relationship in that the more people earn the healthier they are. - Income-health relationship not recreated in *across* OECD countries, ie those with higher GDP per capita are not necessarily healthier (Wilkinson 1996). [Examines ecological relationship with community-level attributes). <u>Explanations</u> - 'Relative' hypothesis: *psychological mechanisms* primarily explain why an individual's income affects his/her health in Western high income countries, not the material resources procured by income ie relies on comparison to peers within countries. Thus focus is on *relative* income, not absolute income, and may explain why income and health are not related between countries.	- Good recent summary of current thinking and debates on income and income inequalities and health that examines the role of social capital. - Emphasis not primarily on mental health

		- Another hypothesis is that 'Risky Behaviours' congregate within income classes, which lead to poor health. If the distribution is similar in countries an ecological relationship between societal wealth and health may not surface. - 'Neo-materialist' hypothesis – structure of society and purchasing power of wealth and/or distribution of risk are important, even in rich countries. (Lynch et al, 2000) support this position with evidence that if Wilkinson's analysis is conducted with expanded no. of OECD countries (33), wealth is related to health between countries. - Wilkinson (2000) challenges that their relationship disappears if the richest only countries are selected ie (in top 21 richest relationship between wealth and health is negative, and non-existent among top 23 with highest life expectancy. ie relative explanation of relationship of relationship between income and health still stands for the rich countries. He does note however, that among the 9 nations in the Luxemburg Income Study there was a relationship between income *inequality* and health. <u>Inequality and health</u> - Other studies have also found evidence of a relationship between levels of income *inequality* and health in US states (Kaplan et al, 1996) and US metropolitan areas (Lynch et al, 1998). - These findings were not repeated however in Canadian studies of a relationship between inequality and health among provinces or among Canadian metropolitan areas. (Canada is more equal than US, and the lack of a relationship could be due to not enough variability in income inequality to manifest a relationship, or due to a threshold effect in that Canadians have maximised the health benefits accrued from relative income equality.) <u>Explanations</u> - Though various measurement/artefact explanations have been postulated, Veenstra concludes that there is some, but not incontrovertible, evidence that the *ecological* relationship between income *inequality* and health is more than simply a reflection of the relationship between income and health among individuals. - Lynch, Kaplan (1997) & Wilkinson (1996) have all postulated (akin	

		to the relative hypothesis) that income inequalities impact on the way people perceive their social environment – which influences their health ie falling short in psycho-social comparisons generates a sense of relative depravation, inferiority, anxiety, low self-esteem, embarrassment and shame. Inequality 'gets under your skin' (Syme) - However, Muntaner & Lynch (1999), Lynch & Kaplan (1997), Lynch et al, 2000) have also postulated an ecological, contextual explanation that considers how income inequalities may be associated with social processes and policies that systematically under-invest in human, physical, health and social infrastructures, which may result in the health consequences. Thus ecological or collective aspects of societies are associated with (tolerate) income inequalities; and the individual-level outcomes such as health status (or population health status) are further down the causal chain.	
Psychosocial and material pathways in the relation between income and health: a response to Lynch et al. **Marmot** M, Wilkinson RG (2001) *BMJ* 322(7296): 1233-1236.	Review that replies to Lynch et al (2000) – below. Emphasise the importance of the psychosocial effects of *relative* deprivation.	Reject the perceived dismissal of the psychosocial effects of relative depravation by Lynch et al. Put forward several arguments that even if basic material needs are met, relative deprivation will still have significant psychosocial effects on health: - the psychosocial effects of relative deprivation involving control over life, insecurity, anxiety, social isolation, socially hazardous environments, bullying, and depression remain untouched by meeting basic material needs. - there is psychosocial importance of consumption, as adequate income, and relative income levels express identity, self image, social status, respectability, less subordination, more autonomy and control and less job insecurity. - there are social gradients in physiological stress hormone measures even among those who are not poor - evidence of a link between inequality *per se* and health - at an ecological level, *inequality in society is correlated with weakened social affiliations, more hostility, aggression, racism, discrimination, and homicide*.	
Gender disparities in mental health. **Astbury** (2001).	Summary of evidence on prevalence rates, risk factors,	Cited evidence that adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social	

World Health Organization Ministerial Round Tables.	correlates and consequences of gender disparities in mental health	disadvantage compared with those experiencing least disadvantage Economic policies that emphasise user-pay and market forces have widened social disparities, ie access to services and support increasingly difficult for lower SES groups Need to consider strong interactions between gender differences, poverty and socioeconomic differentials (education, employment, social roles and rank) Notes that to date social inequalities and health outcomes research has lacked a gender perspective	
World Health Organization. (2000) Women's Mental Health: An Evidence Based Review. Geneva: World Health Organization.	Evidence-based review	Compelling evidence of relationship between SES and certain psychiatric disorders such as schizophrenia, major depression, antisocial personality disorders and substance abuse Cites US National Comorbidity Study (NCS, Kessler et al 1994), sample of 8,098, comparison of lifetime prevalence of mental disorders in lowest versus highest income groups - found lowest income group 1.56 times more likely to have an affective disorder, 2 times anxiety disorder, 1.27 times substance use disorder, and 2.98 times antisocial personality disorder Occupying low social rank limits access to material and psychosocial resources and affects ability to exercise autonomy and decision-making over severe life events; limited access to such resources consistently associated with increased risk of depression	
Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. **Lynch** JW, Smith G Davey, Kaplan GA, House JS (2000) *BMJ* 320(7243): 1200-1204.	Review literature and available data to consider alternative interpretations of the existing strong evidence of the association between income inequalities and health.	Consider two interpretations: - *individual income* interpretation (individual level associations between income and health are sufficient to explain aggregate level associations between income inequality and health) - *psychosocial environment* interpretation (**psychosocial** factors are paramount in understanding the health effects of income inequality) Although they do not deny the negative psychosocial consequences of income inequality, they argue that the interpretation of links between income inequality and health must begin with the *structural causes* of inequalities – and *not* just focus on *perceptions* of that	- Focus is on health per se, not mental health in particular. However, evidence has demonstrated that physical and mental health must be seen as an integrated whole.

		inequality. - A key concern is that a psychosocial interpretation encourages understanding of psychosocial health effects in a vacuum, and this can be appropriated for regressive political agendas leading to claims that we lack the social cohesion of the past; that problems of poor and minority communities are really a result of deficits of strong social networks; and that local communities must solve their own problems. This reinforces low expectations of required structural changes. - Promote a *neo-material interpretation* that says health inequalities result from the differential accumulation of exposures and experiences that have their sources in the material world. Health inequalities reflect a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health and social infrastructure. - The implication is that the solution to reducing health inequalities requires strategic investment in more equitable distribution of public and private resources.	
Social capital – is it a good investment strategy for public health? **Lynch** J, Due P, Muntaner C, Davey Smith G (2000) *Journal of Epidemiology and Community Health*; 54; 404-408.	Challenge the view that in developed countries relative income is the greatest predictor of morbidity and mortality - and that material conditions exert only weak effects (in response to Baum's 1999 editorial and Wilkinson's earlier literature).	Present a neo-materialistic view of health inequalities in which absolute income is a better predictor of subjective wellbeing and health than relative income. The article is accompanied by a reply from Baum (disputing she had rejected the effects of absolute income and expressing agreement with Lynch). It is also accompanied by a response from Wilkinson, which does challenge Lynch et al's interpretation of inter-country comparisons. Wilkinson reiterates his argument for a *psychosocial interpretation* of health inequalities ie that disparities in wealth in themselves have a significant impact on health as a result of **stress and anxiety and depression** - particularly in wealthier countries. He also argues that *unequal societies* are *divisive* and lead to a *loss of civic society*.	- Demonstrates that opinion is divided on the relative importance in the relationship between SES inequalities and physical health of psychosocial effects vs material effects. - Mental health is not the primary focus, but rather as an intervening variable between SES inequalities and health.
Development as Freedom. Amatya **Sen** (1999)	Presents work that has been at the forefront of ideas on 'human' or 'social'	Some relevant messages: - Development is an enhancement of human freedom - which includes good health. (Development is a process of expanding the	- Widely recognised, provides strong theoretical basis for linking economic

New York; Anchor Books	development. Professor Sen is 1998 Nobel Laureate in economics, and Master of Trinity College, Cambridge.	real freedoms that people enjoy and health is a crucial component of freedom.) - Health is integral to the development agenda (health impacts on the lives people can lead, as well as on what they can do as productive agents in the economy and of social & political change.) - Bad health is constitutive of poverty (If poverty is merely low income then the link to health is indirect, but if we think of poverty as basic deprivation of the quality of life and of elementary freedoms and capabilities, then ill health is an aspect of poverty.)	and social development and health - Does not give particular emphasis to mental health
Inequalities in mental health. **Henderson** C, Thornicraft G, Glover G (1998) *The British Journal of Psychiatry* 173(8): 105-109.	Reviews research on the potential aetiology of mental health inequalities in the UK.	Identifies evidence that increased psychiatric morbidity is associated with unemployment, SES, gender (women have higher rates of 'neurotic disorders', men higher rates of drug and alcohol dependence), ethnic group (African-Caribbean have double all-diagnosis rates as White people), inner city residence, and residential mobility.	- Primary focus is on prevalence of clinical mental illness such as schizophrenia – often measured in the population by 'service contacts'

Table C.2.2: SES and Inequalities – association with mental health (empirical studies)

Publication	Aim or Research Question	Content / Findings & Conclusions	Comments
"Nae as nice a scheme as it used to be": lay accounts of neighbourhood incivilities and well-being. **Airey** L (2003) *Health & Place*; 9: 129-137.	Examines how features of place are experienced and interact and to influence wellbeing.	Provides useful summary of key concepts relating to geographical inequalities and their association with wellbeing. - Note: some terminology is the same as that used in social capital literature, but with slightly different meaning ie geographical inequalities may reflect both the aggregated characteristics of individuals living in a specific area (*compositional* factors) and the physical and social features of particular places (*contextual* factors). (Citing McIntyre, 1993) - Recent approaches also emphasise how individuals subjectively experience particular places and the impact their experience / interpretation has on mental and physical health. - Within affluent societies income inequalities undermine social relations. The experience of living at the 'wrong end' of the socio-economic gradient in highly unequal societies directly generates psycho-social stress, and affects wellbeing indirectly by deteriorating the quality of social life. Thus such stress is disproportionately experienced by disadvantaged groups living in disadvantaged areas. - Respondents identify perceptions of a strong relationship between the place where they live and their mental health and wellbeing (but not physical health) - Experiences of 'neighbourhood incivilities' (stigma, shame, loss of social interaction, participation and trust) which are perceived to be the result of living in a deprived area correlate with increased psychosocial stress and reduced sense of wellbeing. - Favourable social comparisons with areas perceived as more deprived than one's own may be used to distance / protect oneself from the negative influence of experienced incivilities on wellbeing.	- Presents empirically derived model of a relationship between the contextual features of a deprived neighbourhood, residents' experiences of these features, and their sense of wellbeing or levels of stress

Relations of income inequality and family income to chronic medical conditions and mental health disorders: national survey. **Sturm** R, Gresenz CR (2002). *BMJ*; 324: 1-5.	National survey in USA examining relationship between differences in income and health outcomes -	- household telephone survey conducted in 1997-98 involving 8,235 adults - outcome measures included self-reported chronic medical conditions, and current depressive disorder or anxiety disorder assessed by clinical screeners - no relation was found between income inequality (measured at community level) and prevalence of chronic medical problems or depressive disorders and anxiety disorders, either across the whole population or among poorer people - however, found evidence of a relationship between family income and education, and some health outcomes including depressive disorder and anxiety disorder	- important distinction between community or population level income inequality, and inequalities in income at the individual family level
Relative contribution of early life and adult socioeconomic factors to adult morbidity in the Whitehall II study. **Marmot** M, Shipley M, Brunner E, Hemingway H (2001). *Journal of Epidemiology and Community Health*; 55: 301-307.	Examines the relative contribution early life and adult SES as predictors of specific physical conditions and depression	- study uses the Whitehall cohort of British civil servants, followed up prospectively for an average period of 5.3 years; participants comprised 6,895 males and 3,413 females aged 35-55 years at baseline - participants' jobs graded from 1 (highest, senior executive) to 6 (lowest, clerical) - results showed that current SES rather than early life SES (i.e. based on each participant's father's social class) predicated adult morbidity including depression - high job grade at entry to the civil service was predictive of depression, but current low grade also predicted depression, suggesting different types of stress leading to depression in these two groups - an important policy implication from this study is that improvement in the conditions in which adults live and work is likely to improve health outcomes independent of earlier disadvantage	
Neighbourhood renewal and health: evidence from a local case study. **Blackman** T, Harvey J, Lawrence M, Simon A (2001)	Before and after study examining the effects of a neighbourhood renewal project on physical and mental health.	Introduction reviews some of literature on poor housing and health + mental health. - The 1982 Black report (Townsend P, Davidson N, eds, Inequalities in Health: The Black Report. Penguine, Harmondsworth) re-drew attention to the detrimental effects on health of poor quality housing.	

Health & Place; 7: 93-103.		- Since the 1980s substantially more evidence has accumulated that poor quality housing is associated with infections, respiratory diseases and chronic illness, as well as depression and anxiety or generic 'psychological distress'. - Both physical ill health and psychological distress are related to overcrowding, damp, mould, indoor pollutants, infestations, cold and homelessness. - Mental health problems have also been linked to unpopular housing areas and high rise flats.	
Race, class and psychological distress: contextual variations across four American communities. **Schwabe** AM, Kodras JE (2000). *Health*; 4: 234-260.	Examines links between race, class, place and distress using theoretical, quantitative and qualitative approaches	- consistent research findings that mental health is relatively poor among those placed at a disadvantage by low education levels, low-status occupations and low incomes - these structural conditions vary geographically, creating different contexts in which mental health problems may manifest - links between race, class and psychological distress (anxiety and depression) vary substantially geographically - "rather than viewing race as a categorization of individuals according to color, race can be conceptualized as a place- and time-specific relation among racial groups, conditioned by the context in which these groups live, work and interact" (p.239) - future research could also examine how gender effects the three-way interaction between race, class and place - economic, political and social factors that effect 'race' differences in psychological distress, especially at low SES levels, are not independent forces - "researchers need to give greater attention to the specific contextual circumstances in which the factors related to human health are embedded" (p.256)	- noted the need to disaggregate 'mental health disorders' to better understand relationships between variables
Underemployment and depression: longitudinal relationships.	Reports on analysis of survey data from National Longitudinal Survey of Youth for years 1992-1994 (in USA)	- used subset of data for those respondents who were employed in 1992, n=5,113 - survey included measure of 'prior depression' so that any	- study shows that a narrow focus on contrasting the unemployed with the employed misses the impact

Dooley D., Prause J, Ham-Rowbottom KA (2000). *J Health Soc Behav*;41:421-36.		relationship between employment status and subsequent depression could control for this potentially confounding effect - also examined range of potentially mediating factors, including gender, marital status and job satisfaction - results showed that becoming unemployed, inadequately employed, or out of the labour force were each associated with increased depression compared with those continuing in adequate employment, after controlling for prior depression and other contextual variables - depression was also higher for females, the less educated, those with lower self-esteem, those with children, and those who were less satisfied with their jobs in 1992 - interaction effects showed increases in depression associated with inadequate employment or unemployment if no spouse was present, if higher educated, and if more job dissatisfaction - so being married appeared to buffer the adverse effects of becoming unemployed or inadequately employed, while years of education and job dissatisfaction appeared to exacerbate the adverse effect of losing a job - adverse employment change did not interact with gender - conclude there is a reciprocal relationship between psychological well-being and employment: those with higher depression (especially those with less education) have greater risk of future job loss; both job loss and inadequate employment are, in turn, related to increased depression after controlling for prior depression - also noted that, although not measured, adverse employment changes likely to have social costs other than depression; previous research suggests links with alcohol misuse, decreased self-esteem and violence - results have implications for helping workers manage depression	of inadequate employment - issue of 'reverse causation' ie depression can cause people to lose their jobs, and ongoing unemployment can foster further depression making it more difficult to find work - most literature has examined one type of employment change: job loss; almost no research on depression and adverse job changes involving inadequate employment (see definitions above)

Childhood and adulthood risk factors for socio-economic differentials in psychological distress: evidence from the 1958 British birth cohort. **Power** C, Stansfeld SA, Matthews S, Manor O, Hope S (2000). *Social Science & Medicine*; 55:1989-2004.	Investigation of relative contributions of childhood and adult life factors as explanations for socio-economic inequalities in mental disorders	- empirical research has confirmed that people from lower SES backgrounds are at increased risk of a range of mental disorders, including schizophrenia, anti-social personality disorder and affective disorders such as depression and anxiety - previous studies on socio-economic gradients in psychological status have tended to focus on a limited range of explanations - the present study examined a large number of childhood and adult factors using 11,405 subjects from the 1958 British Birth Cohort, followed up to age 33 years - at 33 years, 7% of men and 12% of women had a high level of psychological distress, but the prevalence varied by social class: for men from highest to lowest social class, the range was 4-12%, and for women 7-19% - results indicated that both childhood and adulthood factors appeared to be involved in the development of the socio-economic gradient in psychological distress, e.g. the individual's ability at age 7 years was strongly related to both psychological distress in early adulthood and social class; in terms of adult factors, job insecurity for both sexes, and psychosocial job strain for men appeared to be important explanations in adult life for the social gradient in psychological distress - two additional factors were specific to women: age at first child and financial hardship in adulthood - the authors conclude that the findings support the "social causation" explanation for mental health problems - furthermore, there is a cumulative deleterious effect of unfavourable childhood environment and poor ability at age 7 together with unfavourable adult circumstances that contributes to adult psychological disorders. In addition, the factors appear to vary somewhat for men and women - thus interventions to reduce inequalities in adult psychological distress need to be targeted at both childhood and adulthood risk factors	-

Table C.2.3: SES and Inequalities (children/youth) – association with mental health

Publication	Aim or research question	Summary	Comments
America's adolescents: where have we been, where are we going? **Irwin** Jr, CE, Burg SJ, Cart CH (2002). *Adolesc Health*; 31: 91-121.	Literature review of trends in health of America's youth	- various important demographic changes impacting on adolescents including increased proportion of single parent families, increased proportion of working mothers, therefore less adult supervision and more time spent with peers - at school, changes include decreases in the number of schools, increases in class sizes, and decreases in teacher interaction and supervision, leading to "large, unstructured, impersonal environments" (p116) - also broader social trend toward more involvement with electronic media (television, video games and computers) means children are spending more time alone - major causes of deaths among adolescents due to motor vehicle accidents, homicide and suicide - wide disparity between males and females, and between ethnic groups (Black male adolescents have highest mortality) - epidemiological surveys suggest 20% of adolescents use mental health services, 21% of adolescents aged 9-17 yrs have a disorder associated with at least minimum impairment, while 11% have a disorder with significant impairment, however problem of under-diagnosis - high school student survey showed that 23.6% of girls and 14.2% of boys reported seriously considering attempting suicide in the past 12 months	- identify need for more reliable data about mental health problems among adolescents - surprising lack of data about SES effects among adolescents
Socioeconomic status and child development. **Bradley** RH, Corwyn RF (2002). *Annual Reviews Psychology*; 53: 371-399.	Review of evidence on relationship between SES and child development (physical, cognitive, emotional)	- summary of evidence regarding SES and social/mental development of children is as follows - some debate about whether SES should be represented as an issue of class (or economic position) or as social status (or prestige) - capital (material, human and social resources and assets) has become a favoured way of thinking about SES	

		- link between SES and child well-being varies as a function of geography, culture and recency of immigration; some debate about whether SES has the same underlying meaning in all ethnic and cultural groups - substantial evidence that low SES children more often manifest symptoms of psychiatric disturbance and maladaptive social functioning than children form more affluent circumstances - for very young children there is little evidence of a relation between SES and socioemotional well-being, however the relationship emerges in early childhood and becomes reasonably consistent in middle childhood (especially for externalising problems) - among adolescents, low SES is often associated with poor adaptive functioning, increased likelihood of depression, and delinquent behaviour - strength of the relationship between SES and mental disorders varies by type of disorder and race; relationship is most consistent with schizophrenia and personality disorders, reasonably consistent with mild depression, and inconsistent with neuroses and affective disorders - findings are also inconsistent for relationship between SES and substance abuse in adolescents - two broad categories of mechanisms have been proposed for linking SES with child well-being: environmental resources and constraints; and psychological influences; neither have been adequately explored - low SES also frequently occurs with other conditions that purportedly affect children, e.g. minority and immigrant status, single parenthood, family member/s with disability or mental illness, exposure to teratogens and other potentially hazardous environmental conditions) - low SES children are also more often the victims of child abuse, peer victimisation and community violence	

		- therefore, a child from a low SES family can be exposed to a wide range of adverse influences acting independently and in combination; moreover, during the course of childhood, the meaning and significance of these factors may change - most of the research with SES and child development has focused on measures of family SES; authors argue for the need to consider community-level SES and the effects of the neighbourhood of residence on child outcomes	
Children's emotional and behavioural well-being and the family environment: findings from the Health Survey for England. **McMunn** AM, Nazroo JY, Marmot MG, Boreham R, Goodman R (2001). *Soc Sci Med*; 53: 423-440.	Findings from a national survey involving parents of 5,705 children aged 4-15 yrs, conducted in 1997	- analysis examines relationship between family structure, socioeconomic indicators, parental working status and parental psychological status on children's psychological health - found high prevalence of psychological morbidity among children of lone-mothers directly attributable to socioeconomic factors ie poverty and low educational attainment associated with both poverty and lone motherhood - high prevalence of psychological morbidity among children with stepparents not explained by socioeconomic factors; may be associated with prior marital disruption and/or effects of remarriage and/or ongoing conflict - strong relationship between parents' and children's psychological morbidity independent of socioeconomic status and family structure - an obvious implication is to improve the circumstances of single-mothers, specifically their economic circumstances (through social policies), and also opportunities for educational attainment among 'vulnerable' girls	- cross-sectional survey does not allow determination of the causal chain e.g. not possible to determine whether the parents' or child's psychological morbidity occurred first
The influences of race, ethnicity, and poverty on the mental health of children. **Samaan** RA (2000). *J Health Care Poor and Underserved*; 11:100-110.	Review of literature on effect of socioeconomic, cultural/ethnic and racial factors on mental health in children	- results indicate children whose parents are poor or have experience significant economic losses more likely to report or be reported to have higher rates of depression, anxiety and antisocial behaviours - racial differences: after controlling for poverty, ethnic and racial minority children and adolescents have a lower prevalence of mental health problems than white children	- some concerns about quality of the review

		- literature suggests these problems in poor families linked with lack of parental nurturance, inconsistent parental discipline, maternal psychological distress, and negative coping strategies - protective factors include perceived social support, deep religiosity/spirituality, extended families, and maternal coping strategies	
Children in low-income, urban settings. **Black** MM, Krishnakumar A (1998) *Am Psychologist*; 53: 635-646	Review of effect of urbanization on the mental health of children and adolescents, especially those in low-income settings, & recommendations for interventions	- noted that in most industrialised countries (e.g. Australia, USA, Canada, UK) majority of population lives in urban centres - existing literature shows that children living in urban areas compared with those in rural areas have higher rates of delinquency, aggression, violence, psychological disturbances, behavioural problems, child abuse and neglect, and lower educational and occupational expectations - poverty often accompanies urbanisation and is associated with negative physical and mental health outcomes for children	-

Table C.2.4: Inequalities – association with social capital

Publication	Aim or Research Question	Content / Findings & Conclusions	Comments
A glossary for health inequalities. **Kawachi** I, Subramanian SV, Almeida-Filho N (2002) *Journal of Epidemiology & Community Health*; 56(9): 647-652	Summary of current research and outstanding debates on the study of health inequities	The hypothesis is that SES inequalities also impact on health as a result of decreased social investment and erosion of social capital. In addition to the material and psychosocial harms (ie shame, loss of self respect) of income inequalities, there are also hypotheses that the growing distance between rich and poor has a **negative effect** on **social investment** (ie lower state effort on education and welfare); and leads to an **erosion of social capital and social cohesion** (Kawachi et al, 1997 & 2000)	
Social capital for health; investigating the links between social capital and health using the British Household Panel Survey. **Pevalin** DJ, Rose D (2002) (NHS) Health Development	Examines relationship between SES (labelled 'structural factors') and social capital (individual-level measures) and health (including common mental illness).	Introduction to this report includes an overview of empirical research on the relationship between SES, social capital (they focus on individual-level measures), and health. Determine that SES measures are much stronger determinants of health status than social capital (individual-level measures). - Present a theoretical model of the relationship between 'structural factors (SES) + social capital + health, which is tested in their data	

Agency http://www.hda.nhs.uk/documents/socialcapital_BHP_survey.pdf		analysis of the British Household Survey: The model predicts that: - Structural factors determine health, - Structural factors also determine social capital (they emphasise the impact of structural factors on levels of individual social capital, rather than vice versa). - Social capital has some direct impact on health - Social capital may also moderate the impact of structural factors on health. The findings from this study mostly negate the latter aspect of this model (see table 'social capital – association with mental health').	
Social capital & health. **Veenstra** G (2001) *Canadian Journal of Policy Research*; 2(1): 72-81.	Reviews the literature which has interpreted the ecological relationships between income inequality & population health status. Examines the role of social capital in this relationship.	Proposes equality may affect health through its impact on social cohesion or social capital (although the causal pathway also may be that societies with high social capital adopt measures to moderate income inequality). Social capital may contribute directly to health, or result in policies that are more supportive of health outcomes. - Although explanations differ, Wilkinson, Lynch, Kaplan and others present evidence of a relationship between rates of income inequality, social cohesion or social capital, and population health status. - Kawachi, Kennedy et al studied US states & propose that greater rates of inequality results in decreased social capital and cause increased mortality and poorer self-rated health status (although these associations are widely repeated, the explanatory causal pathway are contested). Ellaway & Macintyre found similar results among postcodes in Western Scotland. Veenstra proposes a model of social structure in which there are three interacting spheres: economic system, political system and civic society. - Summarises various definitions of social capital & concludes that multiple social capitals can work to achieve various ends ie promote economic growth and development, performance of political institutions, and health of populations (p76). - Muntaner and Lynch also argue that class relations and politics are part of the inequality-social cohesion-health discourse. Coburn quote - that 'the economy, the state and civil society are, in fact, inextricably interrelated'.	- Good overview of this relatively recent literature and the topics of debate - Mental health outcomes are not the primary focus

		- Suggests however the concept of social capital focus on the sphere of civil society, since most aspects of social structure could be otherwise deemed a health-producing social capital of sorts and social capital becomes all things to all people and loses analytical meaning. However, civil society should always be considered within the larger socio-politico-economic context.	
Social cohesion, social capital and health. **Kawachi** I, Berkman LF (2000). In: Berkman LF, Kawachi I *Social Epidemiology*. New York; Oxford University Press	Overview of the literature.	Identify social capital as a subset of *social cohesion*; ie social cohesion refers to the extent of connectedness and solidarity among groups in society. A cohesive society is also one that is richly endowed with stocks of social capital, thus social cohesion refers to: - **absence** of latent social conflict (**income inequality**, racial tensions, disparities in political participation and other forms of polarisation) - presence of strong social bonds (high levels of *social capital* and *civil society* ie trust and reciprocity and associations that bridge social divisions)	
Social capital – is it a good investment strategy for public health? **Lynch** J, Due P, Muntaner C, Davey Smith G (2000) *Journal of Epidemiology and Community Health*; 54; 404-408.	Emphasise the contingent nature of relations between social capital, economic development, public policy and health.	- Postulate that in health context, social capital has been over-simplified, "under-theorised" and not adequately socialised - ie social capital has tended to be used as a more fashionable label for what used to be considered as the "social support" field and the role of socioeconomic and political structures has been under-examined. They argue that because social capital is not just a population level analogue of social support, the 'buffering hypothesis' (that social support protects against the negative impact on health of stressors) is not adequate for examining the health effects of the ecological concept of social capital (although it can explain the effects of social support at an individual level). - Cite Woolcock (2001) and others to emphasise that social capital is not only about *horizontal* social networks (& development of norms of trust and reciprocity that aid productive activity and promote health); but that it is also about formal social relations of political, legal and institutional structures ie *vertical* social relations. - The vertical relations impose limits on the way knowledge,	- Points to potential overlap for initiatives targeting social capital and income inequalities. - Provides cautionary note re potential negative effects of promoting 'unhealthy' social capital. - Review does not focus on mental health specifically.

		resources and power can be deployed across horizontal/informal networks, and determine the nature of civil society where informal social relations, trust and reciprocity are played out. - Also challenge that social capital is always positive ie if it leads to *coercion*, *exclusion* of minority groups, or *discrimination* then social capital can have a negative effect on health and wellbeing. Caution that *"sectional social capital"* may have a negative impact on a whole society.	

Table C.3.1: SES and Inequalities and mental health - intervention options

Publication	Aim or Research Question	Content / Findings & Conclusions	Comments
Evaluating the impact of a locality based social policy intervention on mental health; conceptual and methodological issues. **Rogers** A, Huxley P, Thomas R, Robson B, Evans S, Stordy J, Gately C (2001) *International Journal of Social Psychiatry*, 47(4): 41-55.	Recommendations to assist with evaluation research.	Urban regeneration initiatives have potential to demonstrate the impact of socio-economic circumstances on mental health. To conduct such evaluations they promote a combination of multi-level modelling, subjective indicators and narrative accounts of individuals about mental health in the context of local environment and personal changes. - Aim is to enable exploration of the action and interactions of effects that may operate at structural and individual levels. (Article identified in last stage of review – only abstract available at the time).	
Social Determinants of Health; The Solid Facts. **Wilkinson** R, Marmot M (eds) (1998). The World Health Organisation, Europe Regional Office. http://www.who.dk/document/E59555.pdf	Summarises the evidence and identifies broad implications of that evidence for policy in ten key areas: - the social gradient - stress - early life - social exclusion - work - unemployment - social support - addiction	<u>Key points from STRESS category</u> - Social and psychological circumstances can cause long-term stress. - Continuing anxiety, insecurity, low self-esteem, social isolation, and lack of control over work and home life have powerful effects on health. - These psychosocial risks accumulate during life and increase the changes of poor mental health and premature death. - Long periods of anxiety and insecurity and the lack of supportive	

	- food - transport	friendships are damaging in whatever area of life they arise. <u>Implications for policy</u> - In schools, businesses and other institutions the quality of the social environment and material security are often as important to health as the physical environment. - Institutions that give people a sense of belonging and of being valued are likely to be healthier places that those in which people feel excluded, disregarded and used. - Welfare programs need to address both psychosocial and material needs as both are sources of anxiety and insecurity. - Governments should support families with young children, encourage community activity, combat social isolation, reduce material and financial insecurity, and promote coping skills in education and rehabilitation.	
Inequalities in mental health. Henderson C, **Thornicraft** G, Glover G (1998) *The British Journal of Psychiatry* 173(8): 105-109.	Reviews research on the potential aetiology of mental health inequalities in the UK.	Propose strategies to prevent impoverishment and provide employment to preventing cycle of worsening SES status among those with mental illness: - introduce a minimum wage without raising disability benefits - reduce disability benefits more gradually when disabled people begin to work - substitute guaranteed jobs at a non-poverty wage instead of a disability benefit for all but the most disabled - pay under-productive disable workers a wage subsidy to make work worthwhile Recommend these options are considered as part of the work of reforming the welfare system and as a component of the implementation of a minimum wage.	- Primary focus is on preventing vicious cycle of mental illness (eg schizophrenia) increasing improverishment and worsening mental health

Table C.3.2: SES and Inequalities - intervention options

Publication	Aim or Research Question	Content / Findings & Conclusions	Comments
Tackling Health Inequalities; a program for action. **Department of Health** (2003). UK. http://www.doh.gov.uk/healthinequalities/index.htm Website includes other related documents eg - NHS (national health service) specific interventions to support the 2010 targets for health inequalities - Health Inequalities Update (newsletter reporting progress), - Guidance from the Department of Health and Neighbourhood renewal unit.	Report sets out UK Government plans to tackle health inequalities over three years – and identifies longer-term targets for 2010.	The cross-departmental plan of action is informed by evidence from 1998 Acheson report (Independent Inquiry into Inequalities in Health) and a 2002 Treasury-led review of existing programs to identify how Government spending could be applied to greatest effect on health inequalities (Cross Cutting Review). Based on this evidence, actions identified as likely to have greatest impact over long term: *- improvements in early years support for children and families* *- improved social housing and reduced fuel poverty among vulnerable populations* *- improved educational attainment and skills development among disadvantaged populations* *- improved access to public services in disadvantaged communities* *- reduced unemployment, and improved income among the poorest* *Program of action is organised around four main themes:* *- supporting families, mothers and children* *- engaging communities and individuals* *- preventing illness and providing effective treatment and care* *- addressing underlying determinants of health; dealing with the long term underlying causes of health inequalities* *Themes underpinned by five principles:* *- preventing health inequalities getting worse by reducing exposure to risks and addressing underlying causes of ill health* *- working through mainstream services, ensuring they are responsive to needs of disadvantaged* *- targeting specific interventions through new ways of meeting need, particular in areas resistant to change* *- supporting action from the centre by clear policies effectively managed* *- delivering at a local level and meeting national standards through diversity of provision.* Action is not to be confined to the most disadvantaged and socially excluded, but rather to improve the health of the poorest 30-40%.	

Four steps towards equity; a tool for health promotion practice. **Health Promotion Service**, **South East Health** & NSW Health Promotion Director's Network (2003). http://www.health.nsw.gov.au/pubs/f/pdf/4-steps-towards-equity.pdf Project Report http://www.health.nsw.gov.au/pubs/h/pdf/equity-project-report.pdf	A tool designed to assist those working in health promotion in NSW to address and support equity at the local and state level.	The tool was developed over two years through consultations with researchers and practitioners and examining case studies of health promotion programs addressing equity. The tool entails four components: - Identifies equity in health principles - Organisational capacity to support effective equity work (eg the elements required by organisations) - Equity strategies in the planning cycle (for planning or review of existing strategies) - NSW Health and equity and health website (case studies, references, other tools and links) (*Website component currently only available to NSW Health Department employees on their Intranet)* A report is also available from South Eastern Sydney Area Health Service, describing how the tool was developed. *NSW Health Promotion Directors Equity Project Report, 2003*.	- Useful tool for health promotion practitioners at the coal face who wish to reorientate policy and practice to address health inequalities.
Socio-economic inequalities in health in developed countries: the facts and the options. **Mackenbach** JP (2003) Chapter 12.3 In: Oxford Textbook of Public Health Online.	Overview of literature on aetiology of health inequalities and options for intervention.	The explanatory models examined point to the following options for intervention and policy: - to reduce inequalities in education / occupation / income - to reduce the effect of ill-health on education / occupation / income - to reduce inequalities in specific determinants (intermediary material, psychosocial, and behavioural factors). A fourth added option: - to increase supply of health care in lower socioeconomic groups.	
Understanding social factors and inequalities in health: 20th century progress and 21st century prospects. **House** JS (2002) *Journal of Health and Social Behavior*, 43(2): 125-142.	An overview based on personal experience of working in the field –paper associated with his acceptance of an award for his contributions to the research.	Emphasises that the large and persistent impact of socioeconomic position on health is significantly explainable by the degree to which exposure to and experience of major biomedical and psychosocial health risk factors are structured by socioeconomic position – particularly as determined by income and race/ethnicity. Educational differences disappear after adjustment for income. Socioeconomic position is identified as a common cause – and potential 'magic bullet' – for addressing inequalities in health.	- Discuss broad concept of health rather than specifically mental health
A strategy for tackling health inequalities in the Netherlands. **Mackenbach**	Overview of policies and interventions, based on a prior program of evaluation	Recommended interventions and policy measures:	

JP, Stronks K (2002) *BMJ* 325(7371); 1029-1032.	research.	*Interventions and policies targeting socioeconomic disadvantage*: - Continuation of policies that promote educational achievement of children from lower socioeconomic families - Prevention of an increase in income inequalities through adequate tax and social security policies - Intensification of antipoverty policies, particularly those that relieve long term poverty through special benefit schemes and help with finding paid employment - Further development and implementation of special benefit schemes for families whose financial situation threatens the health of their children *Interventions and policies to reduce effects of health on socioeconomic disadvantage* - Maintaining benefit levels for long term inability to work, particularly for those who are totally or partially disabled due to occupational health problems - Adaptation of working conditions for chronically ill and disabled people to increase work participation - Health interventions among long term recipients of social benefits to remove barriers to finding paid employment - Further development and implementation of counselling schemes for school pupils with regular or long term health related absenteeism *Interventions and policies targeting factors mediating the effect of socioeconomic disadvantage on health* - Adapting health promotion programmes to the needs of lower socioeconomic groups, particularly by focusing on environmental measures, including introducing free fruit at primary schools and increasing the excise tax on tobacco - Implementing school health promotion programmes that target health related behaviour (particularly smoking) among children from lower socioeconomic families - Introducing health promotion into urban regeneration programmes - Implementation of technical and organisational measures to reduce physical workload in manual occupations. *Interventions and policies to improve accessibility and quality of health care services* - Maintaining good financial accessibility of health care for people from lower socioeconomic groups	

		- Relieving the shortage of general practitioners in disadvantaged areas - Reinforcing primary health care in disadvantaged areas by employing more practice assistants, nurse practitioners, and peer educators—for example, for implementing cardiovascular disease prevention programmes and better care for people who are chronically ill - Implementation of local care networks aiming for the prevention of homelessness and other social problems among chronic psychiatric patients.	
Health inequities in the United States: Prospects and Solutions. **Raphael** D (2000) *Journal of Public Health Policy*; 21(4): 394-427.	Literature overview aimed at identifying public health responses to health inequities - based on literature on the social determinants of health.	Cites 'An alternative 10 tips for Better Health' from Gordon (1999): *- Don't be poor. If you can stop. If you can't, try not to be poor for long.* *- Don't have poor parents.* *- Own a car* *- Don't work in a stressful, low paid, manual job* *- Don't live in damp, low quality housing.* *- Be able to afford to go on a foreign holiday and sunbathe.* *- Practice not losing your job and don't become unemployed.* *- Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.* *- Don't live next to a busy major road or near a polluting factory.* *- Learn how to fill in the complex housing benefit/asylum application forms before you become homeless and destitute.*	- Strongly endorses and promotes considering economic inequality as a public health issue.
Justice is good for our health. **Daniels** N, Kennedy B, Kawachi I (2000). *Boston Review*, Feb/Mar 2000.	Overview of the literature and four social policy examples.	Examines concepts and findings from social epidemiology literature and outlines examples of policy options in the following areas: - Early life intervention (compensatory education and nutrition in early years of life among disadvantaged groups) - Nutrition (supplementation for low income pregnant women) - Work environment (improve levels of worker control in workplaces by increasing variety of different tasks in the production process, encouraging workforce participation in production, allowing more flexible working arrangements) - Income redistribution (radical – commitment to sustained full employment, collective wage bargaining, progressive taxation; or incremental – expansion of the earned income tax credit, increased child care credit, raising minimum wage).	

Table C.4.1: SES and Inequalities and mental health – intervention evaluations

Publication	Aim	Intervention details	Comments
Young people and mental health: a systematic review of research on barriers and facilitators. **Harden** A, Rees R, Shepherd J, Brunton G, Oliver S, Oakley A (2001). University of London.	Report including literature review based on 345 intervention studies on facilitators and barriers to mental health among young people, especially those from socially disadvantaged groups	- vast majority of studies conducted in USA, and 72% of interventions undertaken in education settings - 49% of studies judged to have 'potentially sound' methodological attributes - evidence on the effectiveness of mental health promotion was conflicting; no clear pattern based on type of mental health promotion focus, type of intervention or the person providing the intervention - interventions to promote positive self-esteem appear to be more likely to be effective if self-esteem is the main focus of the intervention, rather than just one component of a broad initiative - studies on depression prevention showed that knowledge-based sessions of short duration are not effective in improving long-term depressive symptoms, risk factors, knowledge, attitudes or intentions - insufficient evidence to recommend school-based suicide prevention (some have been shown to be harmful) - efforts to prevent mental illness or promote mental health require more than presentation of information and include skill development using behavioural techniques reinforced at different levels (classroom, school, home, community, society) - content of interventions needs to be relevant to the context of young people's everyday lives	- most literature is based on work in USA so questions about generalisability - quality of many studies is poor - most interventions have focused on individuals rather than the wider society
Neighbourhood renewal and health: evidence from a local case study. **Blackman** T, Harvey J, Lawrence M, Simon A (2001) *Health & Place*; 7: 93-103.	Before and after study examining the effects of a five year neighbourhood renewal project in Newcastle Upon Tyne in the UK on physical and mental health.	- The housing renewal program costs 5.5 million pounds sterling, and included environmental improvements, external fabric repairs, refurbishment and some demolition of void dwellings, renovation grants for individual dwellings, and improvements to security and road safety. - Residents perceptions of the area and their reports of housing defects before and after the program are presented (1992 – 1997)	- good demonstration of how improvements in the quality of living conditions can significantly improve mental health and wellbeing

		- Psychological distress showed a significant decline between 1992 and 1998: a fall of 10% in adults with one or more mental health problems (cross-sectional sample); and 50% reduction in adults having 'trouble with nerves' in the longitudinal sample. - the prevalence of smoking was halved in both cross-sectional and longitudinal samples. - General physical health status did not change in the cross sectional sample between 1992 and 1998. Physical health status worsened in the longitudinal sample among those aged over 50 years in 1992 (respiratory conditions that appeared age related).	
Improving mental health status and coping abilities for long-term unemployed youth using cognitive-behaviour therapy based training interventions. **Creed** PA, Machin MA, Hicks RE (1999). *J Organiz Behav*; 20: 963-978.	Australian study evaluating short (3 day/5 hrs per day) training course to increase self-esteem and coping skills among youths unemployed for 12 mths or more in Brisbane	- existing research consistently shown that unemployed people have poor mental health scores (e.g. psychological distress, depression, helplessness, self-esteem, coping) than employed people - various forms of interventions for unemployed people including counselling, training, case management, job clubs, drop-in centres, sporting opportunities, resume preparation, free advertising in newspapers and journals - very few reports of the effectiveness of these interventions - training interventions (focus of this paper) tend to provide job-search and occupational skills, as well as improve the mental health of participants so that cope better with their unemployed situation and are more successful in the job-search process - evaluations of these training courses has yielded mixed results; some studies show benefits that persist after the course while others shown to have negative effects such as reported decline in control over one's life and decline in social support - this study evaluated the effectiveness of a training course specially designed to improve well-being and mental health, and provide coping skills for long-term unemployed youth - program based on cognitive-behavioural therapy, and conducted by registered psychologists	- study suffers from small numbers and single location, so generalisability of results not known - nonetheless, the results are discouraging for those who "view training as a panacea for the unemployment problem" (p.976)

		- previous meta-analysis by Dobson (1989) concluded that cognitive therapy was most effective treatment for depression - compared 43 participants vs 22 controls (mean age 19 years) before and after course, and at 14-16 weeks follow-up - found improved wellbeing among participants from pre to post course on all dependent variables: ↑psychological distress, ↑self-esteem, ↑positive affect, ↓negative affect, and ↑four coping scores - subgroup analysis showed improvements in psychological distress were greater for those participants with higher distress pre-course (than those with lower distress pre-course) - follow-up only 22 participants vs 10 controls showed that participants' psychological distress back to pre-course levels, but remaining changes continued - importantly, no significant difference at follow-up between participants and control subjects in having a job (41% vs 50%), but numbers are small - hence, the anticipated link between improved well-being and coping making people better able to tackle return to work not supported by this study - conclude that cognitive-behavioural therapy can have positive effect on psychological well-being and coping ability - coping ability is not static and can be improved through training - suggest that unemployed people who exhibit poorer mental health and lower employment expectations may most benefit from such interventions	
Children in low-income, urban settings. **Black** MM, Krishnakumar A (1998). *Am Psychologist*; 53: 635-646	Review of effect of urbanization on the mental health of children and adolescents, especially those in low-income settings, and recommendations for	offer following recommendations for interventions to promote the well-being of urban children: - consider the social context when evaluating children's needs and developing interventions (ie incorporate the values, culture and norms of the community to ensure contextual validity of programs)	-

	interventions	- build programs with community initiatives and participation (collaborate with multiple community stakeholders and integrate with existing services) - examine alternate pathways and linking mechanisms in the association between context and the well-being of children (e.g. common risk factors for children and families in low-income settings accrue cumulatively, placing children at even greater risk - promote interventions at multiple levels (universal and selective/targeted interventions) - consider developmental changes among children in urban settings (e.g. growing need for autonomy among adolescents) - address issues of resilience in individuals, families and communities as protective factors (e.g. supportive adults, limiting interaction between the family and 'toxic components' of the community, rigorous monitoring by parents of their children (what they are doing and with who), facilitating interactions with institutions and organisations that promote growth especially schools, developing skills and competencies among children to avoid the pressures of urban life) - incorporate accountability and cost into intervention programs - train young professionals to work in urban settings - make intervention programs accessible to urban children and families - develop interventions based on theoretical frameworks and methodological rigor - combine cultural and developmental sensitivity into intervention programs	
Mental health promotion in high risk groups. **NHS Centre for Reviews and Dissemination** (1997).	Review of interventions aimed at children or adults identified as high risk of mental health problems such	High risk children identified: living in poverty, exhibiting behavioural difficulties, experiencing parental separation and divorce, within families experiencing bereavement.	

Effective Healthcare Bulletin 3(3).	as poor self-esteem, anxiety and depression, with the aim of preventing deterioration of mental health.	High risk adults identified: undergoing divorce or separation, unemployed, at risk of depression in pregnancy, experiencing bereavement, long term carers of highly dependent people. Social interventions targeting *children in poverty* that have been evaluated and shown to be effective: - High quality pre-school and nursery education that have produced improvements in self-esteem, motivation, social behaviour, and other social and educational outcomes - Social support visits for new parents to provide them with child rearing skills; support provided by mature 'lay' mothers has shown improvements in maternal mental health and childcare. (Support interventions are less effective when there are unaddressed health and socioeconomic problems) Social interventions targeting *unemployed adults* - A US program aimed at improving job-search, problem-solving skills, and helping participants to cope with set backs has shown better mental health, motivation and employment outcomes that were sustained at 2.5 year follow-up (subsequent trial demonstrated these benefits were confined to those with depressive symptoms, financial strain, low assertiveness, who can be identified at high risk by using a screening tool). - UK trail showed group cognitive behaviour therapy training can increase general mental health, possibly by increasing re-employment in longer term unemployed professionals.	

Table C.4.2: SES and Inequalities – intervention evaluations

Publication	Aim	Intervention details	Comments
Relationships between poverty & psychopathology. A natural experiment. **Costello** EJ, Compton SN, Keeler G, Angold A *JAMA* 2003; 290: 2023-2029.	Intervention that raised some families out of poverty; examined impact on mental health problems in children	- sample of 1,420 rural children aged 9-13 years enrolled in prospective community-based study who received annual psychiatric assessments for 8 years (1993-2000); 25% of sample were American Indian and the remaining predominantly white - half-way through the study, a casino opened on the Indian reservation; a condition of opening was that all Indian families would share a proportion of the casino's profits every 6 months (opening of casino also led to more jobs in the district) - this 'deal' moved 14% of Indian study families out of poverty; 53% remained poor; 32% were never poor; incomes of non-Indian families were unaffected - that is, not all poor Indian families were moved out of poverty by the intervention; just over half remained poor throughout the study - results showed that the children of families raised out of poverty had fewer mental health problems than prior to the intervention; the effects were seen for conduct and oppositional behaviour disorders but not for depression and anxiety symptoms; by the 4th year of the intervention the symptom level was the same in children who moved out of poverty as in children who were never poor - further analysis showed that improved parental supervision accounted for about 77% of the effect of changing poverty level on the number of psychiatric symptoms among the children - although depression and anxiety symptoms were more common in poor children, moving out of poverty was not followed by a reduction in these symptoms - authors conclude that the results support a social causation explanation for conduct and oppositional disorder, but not for anxiety or depression	
Poverty and child mental health. Natural experiments and social causation. **Rutter** M (2003). *JAMA*; 290: 2063-2064.	Editorial on paper by Costello et al., 2003 (above)	- noted that part of the benefit of the casino in the above study is likely to come from the increase in jobs available as well as from the direct income supplement provided to families - noted that it is not clear why the income supplement and greater job availability enabled only 14% of the Indian families to rise above the poverty line	

Community interventions to promote healthy social environments: early childhood development and family housing. **Anderson** LM, Shinn C, St Charles J (2002). *Morbidity and Mortality Weekly Report* Jan 2002, Centers for Disease Control and Prevention.	Two systematic reviews of early childhood interventions and family housing interventions aimed at contributing to healthy and safe environments	- early childhood interventions review based on 17 articles - based on the findings of the review, the report recommends publicly funded, centre-based, comprehensive early childhood development programs for children aged 3-5 yrs at risk of poverty; evaluations of these programs showed improved cognitive and school outcomes, employment, home ownership, reduced teenage pregnancy and lower arrests and incarcerations - 'Head Start' national preschool education program designed to prepare children from disadvantaged backgrounds for entrance into formal education in the primary grades - sought to review 'mixed-income housing developments' but no studies met inclusion criteria - reviewed 'tenant-based rental voucher programs' based on 23 articles - results indicate provision of rental vouchers gives families the choice of moving to the private housing market and neighbourhoods with reduced exposure to violence - noted that no single intervention is likely to protect a child from the effects of 'harmful exposures'; interventions will be most useful and effective if part of a coordinated system of supportive services for families (e.g child care, housing and transport assistance, nutritional support, employment opportunities, and health care)	
Health effects of housing improvement: systematic review of intervention studies. **Thomson** H, Petticrew M, Morrison D (2001). *BMJ*; 323:187-190.	Review of evidence on the effects of interventions to improve housing on health	- identified only 18 primary prevention studies (nine published prior to 1990); interventions included rehousing, refurbishment, and energy efficiency measures - many studies showed some health gains, including improvements in mental health, after the intervention - however, quality of studies was generally poor: samples and effect sizes were small, studies did not control for potentially confounding variables, and several of the studies were quite dated	- query value of including historic studies - acknowledge methodological difficulties in assessing effects of housing on health: poor housing conditions often coexist with other forms of deprivation, response and follow-up rates are often low, and focus on housing is inappropriately

		- lack of comparative information on costs & effects of specific housing improvements	reductionist and fragmentary (need multidisciplinary approach)
Randomised studies of income supplementation: a lost opportunity to assess health outcomes. **Connor** J, Rodgers A, Priest P (1999). *Journal of Epidemiology and Community Health*; 53: 725-730.	Systematic review on effects of income supplementation on health	- identified 10 studies, mostly conducted in the 1960s and 1970s, designed to assess the effects of increased income - 1 of the 10 studies assessed the health effects of 12 months of income supplementation in 54 people with severe mental illness; 9 of the 10 studies focused on non-health related outcomes (e.g. workforce participation, re-offending rates among recently released prisoners) - authors note that the studies could have provided evidence on the effects of income supplementation on health but did not include such measures (hence a lost opportunity); studies also suffered from some design and analysis limitations - authors offer suggestions for other potential income-based interventions, e.g. providing advice and assistance to welfare recipients to ensure they receive their full entitlements (since many do not); and government policy on taxation and minimum wages	

TABLE D – DISCRIMINATION

Table D.1.1: Discrimination (general) – definitions

Publication	Concept	Definition	Comments
Krieger N. Glossary. *Journal of Epidemiology and Community Health* 2001; 55: 693-700.	discrimination	- the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group … this unfair treatment arises from socially derived beliefs each group holds about the other, and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege (taken from the Oxford and Collins dictionaries of Sociology)	
Krieger N. Discrimination and health. In Berkman LF, Kawachi I (Eds.) *Social Epidemiology*, 2000. New York: Oxford University Press, pp. 36-75.	discrimination	- re dictionary definitions above, random acts of unfair treatment do not constitute discrimination - legally, two forms of discrimination: that sanctioned by law de jure) and the other without legal basis but sanctioned by custom or practice (de facto) - conceptualisation of discrimination in terms of six aspects: - *forms* of discrimination: legal, illegal, overt (or blatant), covert (or subtle), institutional (or organisational), structural (or systemic), and interpersonal (or individual) - *types* of discrimination are based on race/ethnicity, gender,	- implication that research into "discrimination" should clearly specify what combination of these six aspects and four measures of exposure is under investigation

		sexuality, religion, disability, age, and social class - *agency* perpetrated by the State, institutions, individuals - *expression* verbal to violent, mental, physical or sexual - *domain* eg. at home, within the family, at school, getting a job, in the workplace, getting housing, getting credit/loans., getting medical care, by the media, from the police or courts, by other public agencies, on the street or in other public settings - *level* individual, institutional, residential neighbourhood, political jurisdiction, regional economy - also defines discrimination in terms of four measures of exposure: - *timing* conception, infancy, childhood, adolescence, adulthood - *intensity* - *frequency* acute vs chronic - *duration*	
Krieger N. Discrimination and health. In Berkman LF, Kawachi I (Eds.) *Social Epidemiology*, 2000. New York: Oxford University Press, pp. 36-75.	discriminate against	- to make an adverse distinction with regard to; to distinguish unfavourably from others - it is 'the State' which establishes the context for discriminatory acts: it can enforce, enable or condone discrimination or, alternatively, it can outlaw and seek to redress its effects (Tomasevski 1993, cited by Krieger 2000)	
Stephan WG, Stephan CW. An integrated threat theory of prejudice. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 2 pp. 23-45.	prejudice	- negative affect (emotions and evaluations) associated with outgroups	

Table D.1.2: Discrimination (general) – conceptual and empirical issues

Publication	Aim	Conceptual points	Research points
Sheppard M. Mental health and social justice: gender, race and psychological consequences of unfairness. *British Journal of Social Work* 2002; 32: 779-797.	Overview of findings of discrimination, social justice and mental health outcomes	- concept of discrimination typically linked to unequal distribution of material goods, but behind this are issues of social justice and fairness that include material dimension but also symbolic dimension - term 'mental illness' covers diverse range of psychological states, each with different characteristics and different causal elements	- by mid 1950s, relationship between class, poverty and mental disorder established, supported by more recent, better designed studies

		- discrimination experienced in day-to-day fashion, in general harassment, in the language used, and in racially motivated violence experienced, but also operates at more macro levels e.g. denial of employment opportunities, lower status and more menial work, etc	- relationship between gender and mental disorder supported but differences for each gender and disorder e.g. more men suffer schizophrenia, more women suffer depression - combination of poverty and gender associated with even higher rates of mental illness than either factor alone
Krieger N. Discrimination and health. In Berkman LF, Kawachi I (Eds.) *Social Epidemiology*, 2000. New York: Oxford University Press, pp. 36-75.	Overview of epidemiological research on discrimination and health	- argues that the purpose of studying health consequences of discrimination is to understand patterns of population health in order to guide policies and interventions to reduce social inequalities in health and promote social well-being - suggests three approaches to quantifying health effects of discrimination: indirectly, by inference, at individual level (eg comparing health outcomes of subordinate and dominant groups); directly, using measures of self-reported discrimination at the individual level; and in relation to institutional discrimination at the population level - assessment of women's socioeconomic position is difficult and individual or household measures are rarely adequate - socioeconomic position also can change over the lifespan, and should be repeat measured at different time points - 'direct' studies of discrimination with self-reports by individuals newer area of research; Krieger identifies only 20 studies using this approach - direct studies consistently show higher levels of self-reported discrimination associated with poorer mental health - note no consistent method for measuring self-reported experiences of discrimination, and any measure is inherently subjective - Krieger argues that measurement should include intensity, frequency, duration and aetiologic period of exposure, measurement of susceptibility, and measurement of relevant covariates - also need for appropriate measurement validation studies - also "uncanny silence on empirical estimates of the prevalence	

		of self-reported experiences of discrimination" (p.56) - population level discrimination studies predominantly have focused on racial discrimination, and mostly in USA - important to recognise that peoples' responses to discrimination, and the associated health consequences, vary - advocates adopting ecosocial theory in studying discrimination and health consequences; provides a coherent way to integrate social and biologic determinants of well-being	

Table D.1.3: Racial discrimination - definitions

Publication	Concept	Definition	Comments
Williams DR, Williams-Morris R. Racism and mental health: the African American experience. *Ethnicity & Health* 2000; 5: 243-268.	racism	- "an organized system that leads to the subjugation of some human population groups relative to others … an ideology of inferiority … with some being inferior to others" (p.244)	
Krieger N. Glossary. *Journal of Epidemiology and Community Health* 2001; 55: 693-700.	racism	- institutional and individual practices that create and reinforce oppressive systems of race relations	
Rollock D, Gordon W. Racism and mental health into the 21st century: perspectives and parameters. *American Journal of Orthopsychiatry* 2000; 70: 5-13.	racism	- definition comprises three elements: – social attention to racial differences among individuals as members of distinct groups; – belief systems concerning characteristic inferiority or superiority associated with group membership; and – patterns of behaviour that differentially affect the esteem, social opportunities, and life chances of members of racial groups as a function of those belief systems (p.5-6)	
Dovidio JF, Kawakami K, Gaertner SL. Reducing contemporary prejudice: combating explicit and implicit bias at the individual and intergroup level. In: Oskamp S. (Ed.). *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter	aversive racism	- a subtle, often unintentional, form of bias that is characteristic of many ingroup members who possess strong egalitarian values and who believe that they are non-prejudiced, i.e. people who want to be fair and just, but who harbour negative feelings and behaviours	

7, pp. 137-163.			

Table D.1.4: Racial discrimination – conceptual and empirical issues

Publication	Aim	Conceptual points	Research points
Brown TN. Measuring self-perceived racial and ethnic discrimination in social surveys. *Sociological Spectrum* 2001; 21: 377-392.	Discussion of methodological issues for measuring self-perceived racial and ethnic discrimination	- showed that relationship between discrimination and mental health varied with question framing about discrimination - measurement difficulties with concept of discrimination because it is usually defined by the victim's appraisal of the perpetrator's intention to discriminate in conjunction with unfair events	- prevalence of self-perceived racial and ethnic discrimination among 586 Black respondents depended on question framing - 'explicit perceived discrimination' "Thinking over your whole life, do you think that you have ever been treated unfairly or badly because of your race or ethnicity?" - 'generic unfair treatment' measured against six questions about unfair events that the respondent subsequently attributed to his/her race or ethnicity - generic unfair treatment but not explicit self-perceived discrimination was predictive of depression
Williams DR, Williams-Morris R. Racism and mental health: the African American experience. *Ethnicity & Health* 2000; 5: 243-268.	Examines relationship between racism and mental health, predominantly in Black Americans	- racism different from individual experiences of racial discrimination and prejudice - historical policy of residential segregation of Blacks in America has been a central mechanism by which racial inequality has been created and reinforced - segregation has limited access to education and employment opportunities and thereby socioeconomic circumstances - ongoing discrimination has resulted in many SES indicators not being equivalent across race e.g. a given level of education many not reflect equivalent skills and training across race	
Rollock D, Gordon W. Racism and mental health	Discusses (in passing) whether racism should be	- noted that there is consensus among scholars that racism is transmitted across generations by reciprocal interactions	

into the 21st century: perspectives and parameters. *American Journal of Orthopsychiatry* 2000; 70: 5-13.	studied individually or structurally	between individuals and the social institutions they create and to which they are subject - important to recognise that racism perpetuated by dominant groups constructing definitions to justify their superiority of the subjugated groups' inferiority, e.g. extensive historical evidence of pathologising of Black American behaviour to justify institutions erected by dominant groups in American society - similarly, assessment and diagnosis of mental health problems developed and interpreted in ways that are consistent with the needs, concerns and skills of those in socially advantaged positions	
Williams DR. Race, socioeconomic status, and health. The added effects of racism and discrimination. *Annals of the New York Academy of Sciences* 1999; 896: 173-188.	Summary of ways in which race and socioeconomic status combine to affect health	- despite overwhelming support for the principle of equality in USA, it typically coexists with a reluctance to support policies that would reduce racial inequalities; in addition, negative stereotypes of minority racial/ethnic populations persist in the USA - complex interaction between racism and SES; racism has generally restricted SES attainment for members of all minority racial/ethnic groups; race is an antecedent and determinant of SES and racial differences in SES reflect, in part, the successful implementation of discriminatory policies - residential segregation has been the key mechanism by which racial inequality has been created and reinforced in USA, determining access to educational and employment opportunities, health care, housing options, etc - historical data shows that convergence between blacks and whites in USA was greatest in 1960s; economic progress of blacks relative to whites then stalled in mid 1970s, and has stagnated ever since; but importantly, income inequality has increased overall and within both racial groups - "The worst urban context in which whites reside is considerably better than the average context of black communities" (Sampson and Wilson, 1995, cited by Williams, 1999, p.183)	- effects of SES and racism on mental health per se only mentioned in passing
Sanson A, Augoustinos M, Gridley H, Kyrios M, Reser J, Turner C. Racism and prejudice: an Australian Psychological Society position paper. *Australian Psychologist* 1998; 33: 161-182.	Position paper on racism from the APS	- "Racism is oppressive, because it involves the systematic use of power or authority to treat others unjustly." (p.164) - old fashioned overtly expressed racism has been replaced by 'symbolic' racism framed in terms of values and ideology - this more modern racism is "… more insidious, entrenched, resilient, and difficult to counteract" than the old-fashioned blatant form (p.165) - examples of institutionalised racism in Australia include under-	

		representation of minority group members in the media, reinforcement of negative stereotypes in the reporting of conflicts involving minority groups, continuing restrictive immigration policies, and limitations in access to education and employment for minority group members, limitation in access to adequate standards of health, housing and basic infrastructure - "racism is not a problem to those who don't experience its effects, that is, the dominant group, yet it is often this group that sets the political and cultural agenda" (p.170) - example of institutionalised racism within the mental health system: fails to provide adequately for minority groups, superficial egalitarianism coexists with subtle institutionalised racism - despite high mental health needs of minority group members, services for these people are often culturally inappropriate, and services and interventions not aimed at their specific needs	

Table D.2.1: Discrimination (general) - associations with mental health

Publication	Aim	Summary	Comments

Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services* 1999; 29: 295-352.	Reviews definitions and patterns of discrimination within USA, and evaluates research methods used to study health effects of discrimination	- uses ecosocial theory as basis for framework to study relationships between discrimination, inequality and health
		- prevalent types of discrimination in USA in 1990s are: racial/ethnic, gender, anti-gay/anti-lesbian, disability, age, and social class
		- different health effects associated with each type of discrimination
		  - racial/ethnic: higher infant mortality among American Blacks and American Indians, and higher age-adjusted mortality rate for Blacks vs whites,
		  - gender: longer life expectancy of women offset by higher rates of disability and illness, high rates of battery and sexual assault/abuse,
		  - gays: higher rates of smoking, suicide and substance abuse,
		  - social class: social gradient of excess morbidity and mortality, with greatest risk among the poor.
		- important to note that people can often experience multiple forms of discrimination
		- three approaches to quantifying health effects of discrimination: indirectly by inference at individual level, directly using self-
			- notes that an important assumption that social justice is the foundation of public health
			- existing research has methodological limitations (see summary) and investigators are only now starting to develop, employ and validate instruments appropriate for large-scale epidemiologic investigations

		reported discrimination, and at population level in terms of institutional discrimination - all methods are problematic; indirectly relies on statistical methods to describe known variance vs unknown variance, self-reported measures are subjective and suffer from variability due to time period of exposure (ever vs recently), domain of exposure (global vs specific situations), intensity and frequency of exposure, target of discrimination (self, family, group overall), and interpretation of findings of relationships for institutional discrimination to individual discrimination	

Table D.2.2: Racial discrimination – associations with mental health

Publication	Aim or research question	Summary	Comments
Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health* 2003; 93: 200-208.	Review of empirical population-based studies of the association between perceptions of racial/ethnic discrimination and health between 1998 and 2002	- identified 47 studies that included at least one measure of mental health (e.g. well-being, self-esteem, control/mastery, psychological distress, major depression, anxiety disorder, other mental disorder, anger) - 38 of 47 studies showed positive association between perceived discrimination and level of mental illness, 0 studies showed negative association, 3 showed 'conditional' association, and 6 showed no association	- considerable variation in methodological quality, with virtually every study having at least one serious methodological limitation e.g. small sample size, limited number of statistical analyses, inadequate controls for potential confounders (including problem that both measures of discrimination and mental health status are self-report), inadequate assessment of discrimination or health status or both, reliance on cross-sectional data - BUT consistency of findings is quite robust - unanswered questions include whether a dose-response relationship exists between

			discrimination and changes in mental health status, how best to measure discrimination, whether acute versus chronic discrimination should be treated differently, effect of individual and contextual factors on one's vulnerability to stressful experiences
Williams DR, Williams-Morris R. Racism and mental health: the African American experience. *Ethnicity & Health* 2000; 5: 243-268.	Overview of US-based research on the ways that racism towards African Americans affects mental health	- suggest that racism adversely affects mental health in at least three ways: 1. institutionalised racism can lead to restricted socioeconomic mobility, differential access to resources, lower SES and poor living conditions; 2. experiences of discrimination can induce physiological and psychological stress reactions 3. acceptance of negative cultural stereotypes of inferiority ('internalized racism') can lead to unfavourable self-evaluations that affect psychological well-being - large population-based US study showed that adults in lowest SES quartile (composite of education, occupation and income) were almost three times more likely to have psychiatric disorder than those in the highest SES quartile, both for Blacks and Whites - National US probability sample study also found strong graded relationship between SES and psychiatric illness	- need for more systematic investigation of the construct 'racism' and its impact on health, especially in terms of multiple dimensions and components - also mediating effects of different coping strategies need to be identified and assessed
Brown TN, Williams DR, Jackson JS, Neighbors HW, Torres M, Sellers SL, Brown KT. "Being Black and feeling blue": the mental health consequences of racial discrimination. *Race & Society* 2000; 2: 117-131.	Examined association between racial discrimination and mental health in national survey of Black Americans (NSBA)	- mental health assessed in terms of 'less serious' psychological distress, and diagnosis of clinical depression - experience of racial discrimination based on a single item "whether you or your family had been treated badly because of your race in the past month?" - results supported link between perceived racial discrimination and psychological distress but only marginally linked to psychiatric diagnosis of depression	- nearly all research on links between racial discrimination and mental health based on cross-sectional data - importance of examining multiple dimensions of mental health in empirical studies - weakness of study that single question of discrimination, and

			limited to experiences in the last month - important to note that individual experience of racial discrimination is one component of 'racism'
Rollock D, Gordon W. Racism and mental health into the 21st century: perspectives and parameters. *American Journal of Orthopsychiatry* 2000; 70: 5-13.	Discussion paper on racism including its influence on mental health	- on an individual level, racism associated with internal stress, general emotional well-being, health and psychophysiology, and symptoms of psychological disorders - on a broader level, institutionalised racism affects the mental health function of both the dominant and subordinate social groups - most common correlates of racism in America are economic injustice and its related social effects - decline of overt aversive racism accompanied by increasing economic disparities and barriers to economic participation	
Williams DR. Race, socioeconomic status, and health. The added effects of racism and discrimination. *Annals of the New York Academy of Sciences* 1999; 896: 173-188.	Summary of ways in which race and socioeconomic status combine to affect health	- existing studies in USA have shown significant differences in health status of different racial groups; studies show that SES differences within each racial group are larger than the racial differences across groups - population-based studies shown that experiences of discrimination are adversely related to both physical and mental health - small body of research suggests that prevalence of negative stereotypes and cultural images of stigmatised groups can adversely affect health status; e.g. internalised racism positively associated with psychological distress, depressive symptoms, substance use, and chronic physical health problems	- effects of SES and racism on mental health per se only mentioned in passing
Kessler RC, Mickelson KD, Williams DR. The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. *Journal of Health and Social Behavior* 1999; 40: 208-230.	National US general population survey of perceived discrimination and mental health (MIDUS)	- assessed 'major life-time perceived discrimination' and 'day-to-day perceived discrimination' - series of questions about discrimination without stipulating basis for the discrimination, but follow-up question on perceived reason for discrimination - found strong associations between perceived discrimination and mental health problems - day-to-day discrimination more strongly related to psychological distress than lifetime major discrimination - no variation in mental health effects depending on perceived reason for discrimination	- important distinction between differential vulnerability and differential exposure

		- results showed that differential exposure to discrimination did not help to explain observed association between lower social status (women, race, education) and mental health problems – this differs from findings by others e.g. Krieger 1990 reported racial discrimination helped explain black/white differences in health outcomes (specifically hypertension) - one-third of respondents aged 25-74 years reported at least one major discrimination experience, and over 60% reported day-to-day perceived discrimination - importantly, a substantial proportion of people not thought to be socially disadvantaged think of themselves as experiencing major discrimination at some time in their life - argue that it is the generic perception of unfairness, not the perceived reason for the discrimination, that is adversely linked to mental health - some socially disadvantaged groups are doubly disadvantaged in that they experience higher levels of discrimination and are more adversely affected by it (i.e. increased exposure and increased vulnerability)	

Table D.2.3: Gender discrimination – associations with mental health

Publication	Aim or research question	Summary	Comments
Emslie C, Fuhrer R, Hunt K, Macintyre S, Shipley M, Stansfeld S. Gender differences in mental health: evidence from three organisations. *Social Science & Medicine* 2002; 54: 621-624.	Gender differences in mental health, single study	- comparison of men versus women working in similar jobs in three white-collar workplaces (a bank n=2176, a university n=1641, and the civil service n=6171); - controlled for domestic and socioeconomic factors; - found women had higher levels of minor psychiatric morbidity than men (based on GHQ), but differences were small and only in the Civil Service sample did differences reach statistical significance - importance of setting needs to be considered in gender studies	
	Summary of evidence on prevalence rates, risk factors, correlates and consequences of gender disparities in mental health	- prevalence rates of depression reported to be at least twice as common in women as men, and depression is most common mental health problem encountered among women - depression predicted to be the second leading cause of global disease burden by 2020 (Murray and Lopez 1996) - “gender difference in depression is one of the most robust findings in psychiatric epidemiology” (p.7) - “no society treats its women as well as its men” and women	

		constitute more than 70% of the world's poor (United Nations Development Report, 1997) - women have consistently higher suicide attempts, but men have higher completed suicide rates - gender-based violence significant predictor of suicidality - women also have twice the rate of post traumatic stress disorder than men - women have higher prevalence rates than men of both lifetime and 12 month comorbidity of three or more disorders - gender differences in help seeking and gender stereotyping in diagnosis confound reliability of prevalence estimates - prevalence for alcohol dependence of 20% for men versus 8% for women, yet alcohol and depression common comorbid diagnoses - factors associated with depression include exposure to poverty, discrimination, violence, socioeconomic disadvantage, low social status, and traditional female gender role	
Patel V, Araya R, de Lima M, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. *Social Science & Medicine* 1999; 49: 1461-1471.	Study of mental health (depression, anxiety and somatic symptoms) in four restructuring countries (India, Zimbabwe, Chile and Brazil)	- strong associations found in all four countries between female gender, low education, poverty and adverse mental health - that is, links between gender inequality, economic inequality and rising income disparity as risk factors for mental disorders	

Table D.2.4: Gay/lesbian discrimination – associations with mental health

Publication	Aim or research question	Summary	Comments
Warwick I, Aggleton P. Gay men's physical and emotional well-being: reorientating research and health promotion. In: Coyle A, Kitzinger C. (Eds.) *Lesbian and Gay Psychology: New Perspectives,* 2002, pp. 135-153.	Overview of factors affecting the health and well-being of gay men (discursive paper)	- historically, construction of homosexuality as a 'pathology' that was both chosen and sinful - similarly AIDS conceptualised as a moral, political or theological problem, and its management was chiefly through segregation, discrimination and exclusion - issues of concern for gay men: violence and intimidation; issues of 'internalised homophobia' (appear to play a role in elevated rates of suicide ideation); and gay men's dissatisfaction with their own body image (linked with eating disorders and steroid use) - in USA research with lesbians and gay men indicate higher rates of substance misuse and depression (especially among	

		gay men due to bereavement/loss arising from AIDS-related deaths) - calls for a more holistic approach to health and health promotion (The Ottawa Charter & Jakarta Declaration) - need to acknowledge that there is not a single gay community, and the interplay of age, class and ethnicity need to be recognised - need to identify individual and interpersonal protective agents and utilise them - need to address issues of discrimination, prejudice, inequality and power to achieve real change	

Table D.3.1: Discrimination (general) – intervention options

Publication	Aim	Intervention details	Comments
Oskamp S. Multiple paths to reducing prejudice and discrimination. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 1 pp. 1-19.	Introductory chapter and overview to book on approaches to reducing prejudice and discrimination	- noted that most of the studies associated with prejudice have been directed at understanding nature, causes and consequences of prejudice; relatively little research has been directed at how to reduce prejudice and discrimination - cites work by Duckitt (1992) which proposes a four-level model of causes of prejudice: – genetic and evolutionary predispositions, – societal, organisational, and intergroup patterns of contact and norms for intergroup relations, e.g. laws, regulations, and norms of segregation or unequal access, – mechanisms of social influence that operate in group and interpersonal interactions, e.g. influences of mass media, education systems, structure and function of workplaces, – personal differences in susceptibility to prejudiced attitudes and behaviours, and in acceptance of specific intergroup attitudes - Duckitt argues that efforts to reduce prejudice and discrimination need to work at all of these levels, but different approaches needed for each level - laws and societal norms are the most powerful arena for changing patterns of social interaction - alternative proposal from Stephan and Stephan (in Chapter 2 of this same book) suggests prejudice is caused by one or more of the following four types of intergroup fears and threats:	

		– realistic threats from an outgroup, – symbolic threats from an outgroup, – intergroup anxiety in interactions with outgroup members, – negative stereotypes of the outgroup. - approaches to reducing prejudice and discrimination can be grouped into three types: behavioural, cognitive and motivational – behavioural includes intergroup contact under specified conditions, cooperative learning techniques, structured intergroup experiences – cognitive includes attempts to change stereotypes and attitudes – motivational includes reductions of feelings of threat from the outgroup, emphasising shared interdependence and accountability for intergroup events and outcomes - most common method, usually with individuals and groups, have been approaches based on the 'contact hypothesis' (stems from Allport, 1954), predicts a reduction in prejudice under the following four conditions: – equal status between the groups in the situation, – cooperative activity toward common goals, – personalised acquaintance (perception of common interests and common humanity), – support for the contact by authorities or local norms - noted that most 'real world' situations don't come close to meeting these conditions; equal status relationships and personalised acquaintance are difficult to achieve under normal circumstances - contact hypothesis, in various forms, has received empirical support; one meta-analysis of 203 studies found a mean effect size of -0.42 (moderate effect) in reducing prejudice - results from contact method with one outgroup found to generalise across social situations to other outgroups thus increasing tolerance and understanding to others	
Stephan WG, Stephan CW. An integrated threat theory of prejudice. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence	Describes causal model of prejudice based on 4 types of threat, and interventions relating to each type	- note that while white Americans generally agree with premises underlying efforts to improve intergroup relations, they increasingly object to the policies that are used to implement them e.g. opposed to affirmative action and use of quotas, opposed to immigration and programs to help immigrants - authors argue that fear and threat play a major role in prejudice;	

Erlbaum Associates, Chapter 2 pp. 23-45.		four basic types of threat: – realistic threats posed by the outgroup to the ingroup, – symbolic threats involving perceived group differences in morals, values, standards, beliefs and attitudes, which threaten the worldview of the ingroup, – intergroup anxiety where people feel personally threatened in intergroup interactions, – negative stereotypes giving rise to negative, conflictual or unpleasant expectations about the behaviour of the stereotyped group - threat model has implications for understanding and improving relations between groups; different types of threat addressed by different techniques - one approach to overcoming feelings of threat is cognitive, and relies on the premise that ignorance causes prejudice, so it may be possible to change real and symbolic threats with information (e.g. through multicultural education or cultural diversity training) - interaction-based programs (such as cooperative learning techniques and intergroup dialogue programs) more likely to be effective in reducing intergroup anxiety and negative stereotypes by providing people with social skills that facilitate intergroup interaction and personal experiences that challenge stereotypes	
Dovidio JF, Kawakami K, Gaertner SL. Reducing contemporary prejudice: combating explicit and implicit bias at the individual and intergroup level. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 7, pp. 137-163.	Discussion of contemporary forms of prejudice and bias	- changing social norms and legislative changes have made discrimination immoral and illegal, and overt expressions of prejudice have declined; however, prejudice and discrimination continue to exist, including persistent overt, intentional forms of prejudice but also subtle, unintentional and, possibly unconscious, forms of bias - authors argue need to better understand new contemporary forms of bias in order to develop appropriate strategies and interventions - whereas traditional forms of prejudice may be combated by using direct and conventional attitude change and educational techniques, addressing contemporary forms of bias requires alternative strategies, such as those based on well-designed intergroup contact - need to recognise the different identities, values, and experiences that groups bring to contact situations, i.e. majority and minority groups frequently have different objectives and perspectives	

Major B, Quinton WJ, McCoy SK, Schmader T. Reducing prejudice: the target's perspective. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 10, pp. 211-237.	Explores how targets of prejudice might help to reduce prejudice	- use psychological models of stress and coping to understand how targets may reduce prejudice in their interactions with prejudiced perceivers
		- identify two types of problem-focused coping: efforts aimed at reducing or destroying prejudicial attitudes, beliefs or behaviours of others **(prejudice destruction)**, and efforts aimed at reducing the likelihood will be treated in a prejudicial way in a particular situation **(prejudice deterrence)**
		- also emotion-focused coping aimed at diminishing the emotional impact of prejudice **(prejudice deflection)**
		- targets may exercise these coping skills on an individual basis or a collective basis (i.e. on behalf of the group to which they belong)
		- targets' most effective and enduring route to reducing prejudice is to use collective problem-focused strategies, but these are rare (they typically involve considerable personal sacrifice of time, money and relationships for the greater good e.g. women who lodge sexual harassment charges; gay soldiers lodging discrimination charges)
		- moderating factors that can influence targets' efforts to implement coping strategies include:
		  − extent to which targets perceive themselves as having some control over the problem of prejudice,
		  − extent to which targets perceive themselves as having some control over their 'stigmatising attribute/s',
		  − extent to which targets can conceal their 'stigmatising attribute/s,
		  − extent to which targets have a sense of group or collective identity and the extent of attachment to that group,
		  − nature of the prejudiced perceiver, e.g. a target's coping skills may vary depending on whether the perceiver is a 'intransigent bigot' or 'red neck', an 'ambivalent skeptic', or a 'well-meaning friend',
		  − nature of the situation, e.g. relative power between target and perceiver, relationship between them, and perceived opportunities for change
		- authors argue differential costs and benefits associated with efforts aimed at prejudice destruction, prejudice deterrence, and prejudice deflection, e.g. destroying prejudice benefits are potentially high but so are costs as it requires high level of effort often prolonged over time; prejudice deterrent strategies likely to	

		involve less cost and less benefit, since they don't usually challenge attitudes, values and beliefs of the perceiver	

Johnson DW, Johnson RT. The three Cs of reducing prejudice and discrimination. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 11, pp. 239-268.	Describe program implemented in schools to reduce discrimination and prejudice, based on building personal relationships among children from diverse backgrounds	- argue that most profound and long-lasting changes to prejudice and discrimination take place through personal relationships with diverse individuals - school environment provides very appropriate environment for personal interactions and relationships between diverse children and adolescents - authors have developed and implemented program to reduce prejudice and discrimination, based on teaching children and adolescents to live and learn within a school culture that promotes caring, personal relationships, and that values diversity and human rights - program known as Three Cs Program: establishing a cooperative community, resolving conflicts constructively, and internalising civic values - authors conducted a meta-analysis of 180 studies comparing relative impact of cooperative, competitive and individualistic experiences on interpersonal attraction; found cooperation usually promotes greater interpersonal attraction than does competition or individualistic relationships - authors therefore advocate for cooperative learning in which diverse students promote each other's academic success and contribute to the overall success of the school (cooperative community) - re conflicts, authors' research shows that students must be instructed about the desirability of conflicts and the procedures that should be used to resolve them (e.g. problem-solving, mediation, negotiation) - re civic values, the other two Cs are associated with a range of values, e.g. commitment to both one's own and others' success; a sense of responsibility to contribute one's fair share of work, respect for the efforts of others and for them as people, behaving with integrity, respecting the rights of others to hold beliefs different from one's own, accepting that one is fallible, viewing issues from all perspectives, etc. - through these values, diverse individuals can become knit together as a community; these civic values therefore must be inculcated in all school members	

Table D.3.2: Racial discrimination – intervention options

Publication	Aim	Intervention details	Comments
Scotland Government. Campaign against racist attitudes. *Scottish Executive News Online*, 24 Sep 2002. www.scotland.gov.uk/pages/news/2002/09/p_SESJ058.aspx (accessed 11 Aug 2003)	Describes government initiative to address racist attitudes through legislative changes and media campaign	- Short media release item describing campaign launch in Scotland to tackle racism - £1 million advertising campaign over 5 weeks - Use of television, cinema, radio and billboard advertising to increase awareness of racist attitudes and behaviour, and highlight negative impact this has on individuals and communities; intended to focus on positive features of diversity as well as tackling negative behaviour - core messages of the campaign include: – diversity and difference are to be respected and celebrated – racist behaviour is unacceptable – tackling racism is everyone's responsibility – tacking racism is part of promoting Scotland's reputation and positive image – tackling racism is part of the vision of a smart, successful Scotland - media campaign contributes to the Race Relations (Amendment) Act 2000, which places a general duty on government and other public bodies to promote race equality	
Rollock D, Gordon W. Racism and mental health into the 21st century: perspectives and parameters. *American Journal of Orthopsychiatry* 2000; 70: 5-13.	Discussion paper on racism including its influence on mental health	- common elements in mental health interventions concerning ethnicity often include raising of consciousness and clearing of cognitive distortions, recognising diverse contexts of oppression, affirming self- and group-identity, increasing self-mastery and autonomous dignity, and working for self- and social improvement - authors also note that racism should be considered within the context of other 'isms' such as sexism, heterosexism, etc - however, the **fundamental question mental health professionals must answer in dealing with racism is whether racism should be addressed on the individual or the institutional level** - some have attempted a combination of both, e.g. examining the psychological impact of racism as a result of the interplay of individual characteristics, and mitigating & aggravating situational & environmental factors - also must acknowledge that the formulations and recommendations for dealing with the problems of racism &	

		mental health are (or should be) specific to the times & circumstances in which we live	
Ring JM. The long and winding road: personal reflections of an anti-racism trainer. *American Journal of Orthopsychiatry* 2000; 70: 73-81.	Personal comments and reflections on becoming an effective anti-racism trainer, predominantly for professional health staff	- discusses role of leader of diversity training workshops, cultural sensitivity training or experiential anti-racism courses - value of such courses depends on addressing power relationships, privilege and oppression, and not just issues of cultural similarities and differences	- no results, discussion paper only
Sanson A, Augoustinos M, Gridley H, Kyrios M, Reser J, Turner C. Racism and prejudice: an Australian Psychological Society position paper. *Australian Psychologist* 1998; 33: 161-182.	Position paper on racism from the APS	Strategies used to combat racism include: - changing stereotypes by providing contact with members of minority groups; - cross cultural awareness training in the workplace (some evidence of effectiveness immediately following the course, 3-mth follow-up showed some slippage but prejudice levels still significantly lower than at pre-course, suggesting the need for continuous interventions; - school programs shown to be effective when integrated into the overall school curriculum on ongoing, long-term basis, cross-cultural issues are taught comprehensively and sensitively, all children in the school are involved and receive such education as early as possible, and teachers have necessary skills, training and resources to implement high quality programs - parenting practices that promote development of 'perspective-taking' and empathy such as listening to the child's point of view, explaining how others are affected by the child's behaviour, negotiating rules and agreements where possible (all based largely on inductive reasoning processes)	- little use or evaluation of effectiveness of media advertising designed to combat racism in the community - considerable evidence that government legislation aimed at changing behaviours has also changed attitudes, e.g. drunk driving, wearing seatbelts, smoking in public places, etc.

Table D.4.1: Discrimination (general) – evaluations of interventions

Publication	Aim	Intervention details	Comments
Aboud FE, Levy SR. Interventions to reduce prejudice and discrimination in children and adolescents.	Describe five types of intervention programs to reduce discrimination and prejudice among children	- five types of interventions: − racially integrated schooling: research indicates greater impact on attitudes and relationships, if combined with at least one other type of intervention, e.g. cooperative learning − bilingual education: research shows better outcomes if this type of schooling (focused on language and culture) is supported by contact with outgroup peers − multicultural and anti-racist education designed to give	

In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 12, pp. 269-293.		students knowledge and attitudes to understand, respect and interact as equals with members of different ethnic groups: little evaluation of outcomes exist, but appears that elements need to include information that challenges stereotypes and discussion of race and racism − training social-cognitive skills, i.e. teaching children new ways of processing information to alter schemas and age-related cognitive structure such as categorisation, that often distort the way children process multicultural information: some evidence of short-term success but no long-term follow-up − role-playing and empathy: development of capabilities useful for all forms of interpersonal and intergroup relations - integrated and bilingual schooling have had some short- and long-term successes, especially in terms of positive relations with cross-ethnic peers, although contact has not always reduced prejudice - major strength of multicultural and anti-racist approaches is their ease of application even in relatively homogenous schools, but less empirical support for reducing prejudice and discrimination - role-playing and empathy have some empirical support but intervention options for large number of students are lacking, and tends to require some special training for teachers	
Pettigrew TF, Tropp LR. Does intergroup contact reduce prejudice. Recent meta-analytic findings. In: Oskamp S. (Ed.) *Reducing Prejudice and Discrimination*, 2000. New Jersey: Lawrence Erlbaum Associates, Chapter 5, pp. 93-114.	Meta-analysis of prejudice reduction programs based on intergroup contact	- one of the major means of reducing intergroup prejudice has been through contact between the groups under optimal conditions; based on the premise that prejudice derived largely from ignorance - historically the contact approach did not give sufficient attention to many cognitive, affective, situational and institutional barriers to positive contact - nonetheless, the 'contact hypothesis' has inspired extensive research; evaluations of effectiveness have reported mixed results, some very positive others not - authors conducted a meta-analysis of 203 individual studies (73% of the studies were from USA), combining 90,000 subjects from 25 different nations - of the 203 studies, 94% found an inverse relationship between contact and prejudice - most research has demonstrated generalisation of effects from immediate participants in contract programs to the entire outgroups, some studies even showed generalisation to other	

		outgroups not involved in the contact - major predictor of the size of the contact-prejudice effects involves whether the participants are from a majority or stigmatised minority group; majority participants reveal much larger mean effects than do minority participants - effect of contact appears to be different for different outgroups (e.g. contact with homosexual seems to produce larger effects than contact with disabled people) - conclude that the meta-analysis results indicate that optimal intergroup contact should be a critical component of any successful effort to reduce prejudice - identified 6 issues relevant to the practical problems of achieving 'optimal contact': – programs to reduce prejudice should incorporate the four situational elements recommended by Allport (1954, see Oskamp, 2000, Chapter 1) and foster cross-group friendship, – perspectives of both groups must be considered when designing optimally structured contact situations, – optimal intergroup contact has the potential and should be designed in such a way to seek to improve several components of prejudice, i.e. affect, beliefs, social distance and stereotypes, – contact in work and organisational settings has far stronger effects than those typical of travel and tourism settings, – important to actively create situations that counter prevailing negative stereotypes, – social-structural changes in institutional settings are necessary to provide opportunities for optimal intergroup contact on a scale sweeping enough to make a societal difference; yet such changes are typically resisted by powerful majorities	

Table D.4.2: Racial discrimination – evaluations of interventions

Publication	Aim	Intervention details	Comments
Hill ME, Augoustinos M. Stereotype change and prejudice reduction: short- and long-term evaluation of a Cross-cultural Awareness Programme. *Journal of Community & Applied Social Psychology* 2001; 11: 243-262.	Evaluation of a program aimed at reducing prejudice towards Aboriginal Australians	- authors note little evidence of formal evaluations of prejudice reduction programs, and designing such evaluations is difficult, since such programs typically use a variety of methods and assessing whether, or what, is effective is problematic - few existing evaluations have only examined short-term outcome (usually immediately after delivery of an intervention) - noted that the most influential and well-known social psychological method of prejudice reduction is the 'contact hypothesis' (via intergroup contact); more recently, use of social cognitive perspective focussed on changing group stereotypes by providing stereotype-disconfirming information - also found that 'cooperative tasks' leading to a common goal shown to be effective in encouraging positive intergroup interaction for adults and children - authors summarise three prejudice reduction programs: − Cultural Awareness Program in USA – undergraduate program to increase awareness about racism on campus and in society; evaluation results showed students were not significantly more positive towards people of other ethnic backgrounds and did not report more positive social interactions with them; noted high attrition rate from program attendance, − Shared Learning Program in UK – program to increase interprofessional cooperation between doctors and social workers (based on contact hypothesis), results showed significant improvement in intergroup attitudes, and − Police-Schools Liaison Program in UK – program to improve students' attitudes and perceptions of police by placing an officer in the school on a fulltime basis, results showed that students did not perceive the officer as a 'typical policeman' and rated the officer as more caring than police in general, thus the positive effects did not generalise to the intergroup context. - present study targeted employees of a large public health organisation (in Sth Australia), assessed knowledge, attitudes and stereotyping prior to the program (T1), after the program (T2) and 3 months later (T3) - aims of program to increase knowledge of Indigenous history	- study limited by small numbers, no control group, and poor follow-up rate - authors question whether statistically significant results are of practical significance

		and culture, and reduce prejudice towards Aboriginal peoples; program led by Aboriginal employees who had volunteered as group facilitators; it was intended that fellow workers would be accepted as peers while at the same time being members of the target outgroup - 62 participants from 6 workshops participated in the evaluation; only 31 (50%) returned follow-up questionnaires at T3 - comparisons between T1 and T2 showed positive effects: increased knowledge, reduced racism scores, decrease in negative stereotyping and increase in positive stereotyping; facilitators were rated as 'moderately typical of most Aboriginal Australians' - comparisons between T2 and T3 (with 31 participants only) were much less encouraging: knowledge had declined although still higher than T1, racism scores, and negative and positive stereotyping returned to T1 levels - concluded program had short term effects that were not sustained over 3 months - authors conclude that "… the effectiveness of such prejudice reduction programs must be seriously questioned given their excessive focus on locating prejudice and racism within the psychological and cognitive domain of the individual, rather than, or in addition to, the oppressive structural arrangements and power relations within society" (p. 260) - recommend systematic and comprehensive attack at all levels i.e. individual, intergroup and institutional/structural	

E – COLLECTIVE TRAUMA AND VIOLENCE

Table E.1.1: Collective trauma and violence experienced by Indigenous peoples – conceptual and empirical issues

Publication	Concept	Conceptual points	Research points
Commonwealth Department of Health and Ageing. *Draft Consultation paper for the development of the national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional well-being, 2004-2009*, 2003. Social Health Reference Group, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing ACT, Commonwealth of Australia. http://www.health.gov.au/oatsih/pubs/pdf/sewb.pdf (last accessed Jan 2004)	Provides a detailed plan for mental health and social and emotional well-being for Indigenous people	- noted that concepts of mental health and mental illness do not sit comfortably with many Indigenous people; rather prefer 'social and emotional well being' because it better relates to Indigenous peoples' holistic view of health	

Maher P. A review of 'traditional' Aboriginal health beliefs. *Australian Journal of Rural Health* 1999; 7: 229-236.	health illness	- important differences between mainstream culture and Aboriginal culture regarding health beliefs - review focuses on health beliefs of Aboriginal people from rural and remote regions; lack of material describing health beliefs of people living in urban settings - traditional health beliefs linked with various aspects of Aboriginal life including land, kinship obligations and religion, although some variations exist across communities - illness caused by social and spiritual dysfunction; illness categorised as natural, environmental, supernatural, or Western - alternative model divides people into four broad categories in regard to their health: the strong, the weak, the wounded, and the sick - both models regard supernatural intervention and sorcery as the main cause of serious illness; sorcery usually an explanation which is applied retrospectively to explain deaths, serious illness or injury; Aboriginal customary law views sorcery as illegal but it is believed to be on the increase - clear-cut divisions between men's business and women's business; breaches of these divisions likely to cause great distress and 'shame' - "There is poor compatibility between the underlying values of the Western medical system and traditional Aboriginal health beliefs. Western medicine is primarily interested in the recognition and treatment of disease. Traditional medicine seeks to provide a meaningful explanation for illness and to respond to the personal, family and community issues surrounding illness. Traditional medicine explains not only the 'how' but also the 'why' of a sickness." (p.234) - therefore, in any health-related situation, Aboriginal people should be given a clear explanation of the illness or death, and the cause - differences in perceptions of the cause of ill health or disability will affect management, compliance and how the person (and family and community) react to the illness or disability - lack of a common conceptual framework may be a key factor in issues such as treatment compliance and patient satisfaction	- conceptual differences about health will impact on how problems are defined and what strategies are developed to address them

Table E.2.1: Collective trauma and violence (general) – associations with mental health

Publication	Aim or research question	Summary	Comments
Pedersen D. Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Social Science & Medicine* 2002; 55: 175-190.	Review of studies on the short and long-term impact of political violence	- introduces concept of 'collective suffering' following trauma - since WWII there have been about 160 wars and more than 24 million war-related deaths - civilian casualties make up about 90% of all war-related deaths in current times - war associated with significant social disruption and dislocation, including family loss, disruption of daily life, lack of shelter and food shortages, dismantling and destruction of local services and infrastructure - also associated with re-emergence of infectious diseases, unexpected disease outbreaks, emergence of new epidemics (eg. HIV-AIDS, Ebola), increasing malnutrition, poor health outcomes, and towering rates of mental illness and behaviour-related conditions - long term effects of war and atrocities has focused on symptoms such as anxiety, depression, alcohol and drug abuse, and chronic PTSD; the vast majority of studies have been on the latter - PTSD - majority of victims of war are women, children and the elderly - noted that migrants and refugees exhibit various forms of resilience and survival strategies to cope with trauma and overcome adversity - experience of trauma, war and loss not only has negative consequences; can mobilise social cohesion and demonstrate individual and community resilience	- relative absence of studies of populations most affected by war i.e. people in developing countries; of the 135 studies included in this review only 6% (n=8) were conducted in developing countries
Norris FH, Friedman MJ, Watson PJ, Byrne CM, Diaz E, Kaniasty K. 60,000 disaster victims speak: Parts I and II. *Psychiatry* 2002; 65: 207-260.	Review of empirical literature on people involved in 'disasters', risk factors and levels of impairment, published between 1981-2001	- review focuses on disaster not trauma; i.e. acute collectively experienced events with sudden onset (thereby excluding research on chronic hazards or ongoing political conflicts and war) - also, disasters for which there is limited evidence were excluded eg studies of bioterrorism - review identified approximately 250 articles, chapters and books covering 160 samples totalling 61,396 individuals - grouped disasters into three categories: *Natural disasters* (55%): earthquakes, hurricanes, typhoons, cyclones, floods, wildfires, volcanoes, tornadoes, avalanche; *Technological disasters* (34%): airplane crashes, ground transport accidents, industrial accidents, ship, ferry or boat	- literature is best described as series of case studies, and generalisability of any one study's results is therefore limited; meta-analysis helps overcome this problem - much of the literature is 'opportunistic' in that a disaster occurs and investigators rush in; concerns about

		wrecks, nuclear accidents, building fires or collapses, oil or chemical spills, dam collapse; *Mass violence* (11%): shooting sprees, sniper attacks, bombings and other terrorist attacks, mass suicides, civil disturbance - wide range of reported outcomes and symptoms as follows: specific psychological problems (posttraumatic stress, depression, anxiety) assessed in 77% of samples; PTSD most commonly identified condition, followed by depression - various somatic and physical health problems observed - secondary stressors associated with day-to-day living and interpersonal relationships also common, compounding effects due to the disaster per se - victims of disasters often experience loss of psychosocial resources such as social support, self-efficacy, perceived control - importantly, potential support providers for disaster victims are often victims themselves - authors classified outcomes and impairments into four groups of severity; 18% of sample assigned 'very severe impairment' score - risk factors for impairment were: youth (rather than adults), from developing (rather than developed) countries, and experienced mass violence (rather than natural or technological disasters) - within adult samples, adverse outcomes associated with more severe exposure, female gender, middle age, ethnic minority status, secondary stressors, prior psychiatric problems, and weak or deteriorating psychosocial resources - within youth samples, family factors were primary determinants, and outcomes in addition to PTSD, depression and somatic complaints included behavioural problems, hyperactivity and delinquency - general trend for symptoms and impairments to peak during first year and then decline over time - good psychological outcomes associated with victim's *perception* of capacity to cope and control outcomes, social embeddedness, social support, and close social networks	experimental designs and scientific rigor must often take a back seat in response to other needs in a crisis situation - no need for more research to establish that severely exposed diaster victims develop psychological problems; now need more sophisticated research about the diverse needs of different populations, understanding family and community processes, effective community-based interventions, and strategies to help foster resilience and reduce vulnerability

Table E.2.2: Collective trauma and violence experience by refugees and asylum seekers – associations with mental health

Publication	Aim or research question	Summary	Comments
Sabin M, Lopes Cardozo B, Nackerud L, Kaiser R, Varese L. Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after the civil war. *JAMA* 2003; 290: 635-642.	Estimates prevalence of mental illness and factors associated with poor mental health in Guatemalan refugee communities located in Chiapas, Mexico.	- Study involved 5 out of 60 refugee camps in Chiapas, Mexico, cross sectional household survey, one adult (over 16 yrs of age) per household included in the study - Two screening tools were used; the Harvard Trauma Questionnaire (HTQ), a scale that measures symptoms of posttraumatic stress disorder and traumatic events; and the Hopkins Symptom Check list, which measures elevated symptom scores for anxiety and depression - psychiatric morbidity was highly prevalent within this study population - 20 of 170 respondents (11.8%) met the symptom criteria for PTSD, 65% of the 20 were women. Another 20 respondents had all but one of the PTSD criteria. Respondents that met the criteria were more likely to be between the ages of 36-80 yrs of age; have been close to death; have witnessed an assassination, the disappearance of others, a massacre or being sexually abused or raped; be living with 9 or more persons; or have lived in 3 or more camps - 87 of the 160 respondents (54.4%) had elevated anxiety symptom scores women compromised 54% of the 87 - 62 of the 160 respondents (38.8%) had elevated symptom scores for depression, of which 68% were women - not possible to determine whether, or to what extent, these mental health problems were caused by the violence or trauma experienced during the war in Guatemala, or as a result of life in the refugee camps in Mexico	
Hollifield M, Warner TD, Lian N, Krakow B, Jenkins JH, et al. Measuring trauma and health status in refugees. A critical review. *JAMA* 2002; 288: 611-621.	Methodology paper about measurement of trauma and its health effects on refugees, drawing on 183 studies	- refugees demonstrate high risk for post-traumatic stress and depressive symptoms - also high prevalence of dental, nutritional, infectious and paediatric illness - experience multiple symptoms indicative of poor health outcomes, perhaps due to many types of insults experienced - prevalence estimates of health outcomes vary widely depending on definitions and measurement tools e.g. prevalence of post-traumatic stress symptoms (4-86%), depressive symptoms (5-31%) - review concludes that majority of papers are either descriptive or include quantitative data based on instruments that have	- note that refugees viewed as a specific population experiencing trauma - trauma experienced by refugees may precede and post-date experiences related to war and conflict, and effects will vary across individuals and communities, so

		limited or untested validity and reliability in refugees. Measurement tools lack a theoretical base and do not incorporate sound measurement principles - among the 183 papers reviewed, there were 125 different instruments and only 12 of these were developed and tested specifically in refugee research, no test met all criteria recommended for a developed instrument - improving measurement necessary in order to better understand association between traumatic events and health outcomes among refugees	identifying the factors that specifically influence health outcomes is difficult
Steel Z, Silove D, Phan T, Bauman A. Long term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. *Lancet* 2002; 360: 1056-1062.	Assesses long term effects of trauma on mental health and disability in Vietnamese refugees resettled in Australia	- few longitudinal studies have been carried out, and those that have appear to be limited to a 3 year follow-up period - sample of 1,161 households of Vietnamese origin in five local government areas in NSW - after an average time since leaving Vietnam of 14 years, 8% had ICD-10 mental disorders, most commonly PTSD and major depressive disorder - exposure to trauma was the most important predictor of mental health status; risk of mental illness fell over time, however when the exposure to trauma events rose to higher then 3, the risk of mental illness heightened after 10 years in comparison to people who experienced no events of trauma - participants with a mental illness reported more days when they were unable to work or undertake normal daily activities. They also had a higher association of consultations with primary health care workers - most Vietnamese refugees were free from overt mental ill health	- good coping ability demonstrated by most refugees, however people who have exposure to more events of trauma appear to be more susceptible to mental illness - study focuses on ICD-10 mental disorders, not less 'severe' mental health problems
Momartin S, Silvone D, Manicavasagar V, Steel Z. Range and dimensions of trauma experienced by Bosnian refugees resettled in Australia. *Australian Psychologist* 2002; 37: 149-155.	Provides description of trauma experienced by Bosnian Muslim refugees in Australia and investigates whether specific 'trauma domains' can be derived statistically	- detailed case histories of exposure to multiple trauma taken from 126 Bosnian refugees - principle components analysis identified four dimensions/sources of trauma: - <u>Factor 1</u> Human Rights Violations and Extreme Traumatic experiences, this included burnings, beatings, being kicked, being forced to handle human remains and detention - <u>Factor 2</u> Dispossession and Eviction, losing one's home and being evicted from their city; this entailed more then loss of material possessions but also 'fundamental loss of community and coherence of traditional society as a whole' - <u>Factor 3</u> Threat to Life, comprised of severe lack of food, water, hygiene and medical assistance and the continuous threat of death.	- promotes the importance of research based on actual case histories and from there develop emerging factors

		- Factor 4 Traumatic Loss of Family - these factors can be seen as universal core dimensions within the context of civil wars and genocidal conflicts, other factors may emerge in other contexts - certain dimensions of trauma, like the threat to existential meaning systems, may not be evident if research limits itself to using list derived from classification systems like the DSM-IV. Highlights the importance of research to be based on case histories	
Professional Alliance for the health of asylum seekers and their children. *Submission to the Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention*. 2002.	Focuses on the mental and health issues of children in detention	- argue that ecological and environmental systems that surround the child will facilitate or hinder development (p.5) - "Bronfenbrenner's ecological model of child development portrays nested layers of influence on children that begins with the family who are more immediate, but then moves into the neighbourhood, the community and the greater social and economic environment" (p.7) - developments in brain research illustrate that establishment of sensory and intellectual pathways present "…a window of opportunity and a window of vulnerability" (p.6) - adverse effects of early trauma on neurobiological and physiological development - argue that traumatic events experienced by children in detention (such as exposure to adult distress and self harming behaviours, separation from attachment figures, cultural dislocation) likely to have a detrimental effect on early brain development (p.6) - research has shown that children (and adults) seeking asylum experience multiple traumas that have immediate and long term effects on psychological and emotional well-being - consistent results from assessments of asylum seekers show very high rates PTSD, depression and anxiety	- Bronfenbrenner's ecological model emphasises the complexity of factors that have an impact on child development, and can variously benefit or hinder mental well being; fits in well with social capital and social environment frameworks
McKelvey R, Sang DL, Baldassar L, Davies L, Roberts L, Cutler N. The prevalence of psychiatric disorders among Vietnamese children and adolescents. *MJA* 2002; 177: 413-417.	Prevalence of psychiatric disorders among Vietnamese children and adolescents living in Perth	- previous studies of refugee children resettling abroad have reported higher prevalence rates of psychiatric disorders than in non-refugee children living in the same countries - sample of 519 Vietnamese children aged 9-17 yrs, living in households in Perth (i.e. not in refugee camps) - 54% had been born in Vietnam, 36% had lived in a refugee camp, and 5% had witnessed or experienced traumatic events - 92% spoke English well or very well, and only 1.7% were in bottom third of class at school - interviews with parents and children showed very poor	- clinical and methodologically sound study, with cross-culturally appropriate methods - nonetheless tools used to assess psychiatric problems are based on Western concepts of mental illness

		concordance on specific diagnoses (0.6%) - prevalence of psychiatric disorders among Vietnamese children and youths was 15.8% using child reports, and 4.4% using parent reports (combined rate 18.3%); majority of disorders were anxiety-related - combined prevalence rate similar to that found in the Western Australian population (17.9%) and other parts of Australia - "…(there) appears to be a direct and negative correlation between the length of time Vietnamese children have spent in their new homeland and the prevalence of mental disorders experienced by them" (p.416) - need to have clinical services that are sensitive to the cultural traditions of the people being treated	- does not identify factors that enabled children and youth to cope with their migratory events - perhaps could be due to relatively low level of trauma and highly effective acculturation into the community
Mollica RF, Cui X, Mcinnes K, Massagli MP. Science-based policy for psychosocial interventions in refugee camps: a Cambodian example. *Journal of Nervous and Mental Disease* 2002;190: 158-166.	Analytical approach to determine the mental health risk and protective factors associated with a large-scale refugee detention.	- reanalysed the data from a previous study undertaken with Cambodian refugees detained on the Thai-Cambodian border - proposes that research in this area needs to take into account 'the agent' – trauma, 'the host'-the personal characteristics of the refugee, the environmental conditions- social supports, material deprivation and economic opportunities in the refugee setting - study was based on key-informant interviews, epidemiological survey of a systematic sample of refugees aged 18 or older. Screening tools used were the Harvard Trauma Questionnaire (HTQ), Hopkins Symptoms Checklist (HSCL-25) – to measure emotional distress, it compromises of two subscales one measuring anxiety and the other depression - results: found a positive result between respondents older then 44 years of age being more than twice more likely to have symptoms of PTS. Moderate level of education was associated with a lower risk of PTSD. Gender and family size were not associated with PTSD. Depression has similar associations as PTSD however being female increased the risk. - work status was associated with depression, non working respondents were 44% more likely to have symptoms of depression - respondents who participate in personal and formal religious practise, were 1/3 as likely to have PTSD	- proposes that refugees have an extraordinary capacity to protect themselves against mental illness. To have the opportunity to work and practice indigenous religious practices appear to have a protective effect.
Mollica RF, Sarjlic N, Chernoff M, Lavelle J, Vukovic IS, Massagli MP. Longitudinal study of	Three year follow-up study of Bosnian refugees originally living in a refugee camp in Croatia	- found that 45% of the original respondents who met the criteria for depression & PTSD continued to have these disorders, 16% who were asymptomatic in 1996 had developed one or both disorders by 1999	- rare to have a follow up study in a post conflict setting

psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *JAMA* 2001; 286: 546-554.		- 46% of respondents who met the disability criteria continued to do so by the post test - social isolation, being male and older age were associated with mortality - emigration was associated with spending less than 12 months at the refugee camp, experiencing 6 or more trauma events and being more educated and not having an observed handicap	

Table E.2.3: Collective trauma and violence experienced by Indigenous peoples – associations with mental health

Publication	Aim or research question	Summary	Comments
Commonwealth Department of Health and Ageing. *Draft Consultation paper for the development of the national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional well-being 2004-2009*, 2003. Social Health Reference Group, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing ACT, Commonwealth of Australia http://www.health.gov.au/oatsih/pubs/pdf/sewb.pdf (last accessed Jan 2004)	Provides a detailed plan for mental health and social and emotional well-being for Indigenous people	- cites evidence of significant mental health problems among Aboriginal and Torres Strait Islanders, e.g. more than twice as many deaths associated with mental and behavioural disorders, and three times more deaths resulting from accidents, assaults and intentional self harm than other Australians (ABS data); and higher rates of mental disorders correlated with higher rates of substance misuse (Rumbalara 2001); and severe social disadvantage contributing to disproportionately high rates of health and mental health problems - earlier death, child removals, incarceration rates, suicide rates and infant mortality contributing to higher rates of grief, loss and trauma	
Thibeault M. Fostering healing through occupation: the case of the Canadian Inuit. *Journal of Occupational Science* 2000; 9: 153-158.	Overview of the effects of displacement experienced by Canadian Inuit people.	- noted deprivation of traditional modes of occupation, nomadic lifestyle, leisure, as well as cultural erosion and spiritual displacement arising from colonisation and more recent global changes including environmental bans on seal products - this social dislocation linked to poor health (mental and physical) - drug and alcohol abuse and addictions, violence, depression, suicide significant problems among Inuit communities	- broad overview, not looking at conceptual issues or specific findings from a study
Brown R. Indigenous mental health: the rainbow serpent awakening.	Discussion of meaning of mental health for Indigenous people in Australia	- Indigenous people have holistic approach to health, i.e. look beyond the well-being of the individual, and include social, emotional and cultural well-being of entire community	- suggests education and use of grief framework as way forward; but issues

International Journal of Psychiatric Nursing Research 1999; 4: 475-481.		- mental health therefore considered with context of total Aboriginal experience and history of "… oppression, racism, environmental circumstances, economical factors, stress, trauma, grief, cultural genocide, psychological processes and ill health" (p.476) - hence multifaceted trauma resulting from loss of culture, language, land, identity, stolen generation etc, associated with significantly higher levels of stress and anxiety - high incidence of psychological and mental health problems further exacerbated by substance misuse, domestic violence, youth suicide, assaults, unemployment, poverty and petty crime - need for educating mainstream mental health workers and educating Aboriginal communities about health services	are complex and likely to require more comprehensive strategies

Table E.3.1: Collective trauma and violence experienced by refugees and asylum seekers – intervention options

Publication	Aim	Intervention details	Comments
Saltzman WR, Layne CM, Steinberg AM, Arslanagic B, Pynoos RS. Developing a culturally and ecologically sound intervention program for youth exposed to war and terrorism. *Child & Adolescent Psychiatric Clinics of North America* 2003; 12: 319-342.	Describes public mental health approach used to develop school-based post-war trauma/grief intervention program for adolescents in Bosnia-Herzegovina	- key elements of approach include: – development of multilateral partnerships with local and ministerial stakeholders, – systematic and detailed understanding of participants' range and severity of trauma and loss experiences, current adversities and trauma 'reminders' – training program to develop capacities of local service providers, and – indigenous support infrastructure so that program can be directed and sustained by people within the community	- full reference could not be obtained; only Medline abstract sighted
Ferris E. Building hospitable communities. *Refuge* 2001; 20: 13-19.	Explores global trends and details some of the complexities addressing integration of refugees and other migrants.	- survey of immigrants in Finland in 1996-1997 showed 18% had been victims of serious crime - racism and xenophobia within the host country elevate feelings of isolation, shame and guilt experienced by asylum seekers. It also negates a sense of safety and security within the host country - government policies can either accentuate racist trends or work towards confronting them - Ireland currently involved in major information campaign aimed at new arrivals and the receiving community; Canadian Govt has an integration promotion with themes like 'Canada, we all belong' and 'Welcome Home'	- a broad overview, does not specifically focus on mental health

		- citizenship requirements for new arrivals can be lengthy and complex, and seen as exclusionary - receptivity of host communities to new comers needs to be facilitated at various levels, e.g. governmental policies, media, and at communal level	
Mitchell G. Asylum seekers in Sweden: an integrated approach to reception, detention, determination, integration and return What next? *A public forum on Asylum seekers in Australia - 13 September 2001, Storey Hall RMIT, Melbourne* http://www.mams.rmit.edu.au/zmh4rat88jpf.pdf (last accessed December 03)	Details changes to the Swedish Government's approach to asylum seekers, since an enquiry in 1997	- Sweden has a comprehensive and well planned reception, detention, return and integration system, based on clear governmental guidelines, enforcement of policy as well as how the asylum seekers are to be treated - average stay in a Swedish detention centre is 47 days - majority of asylum seekers in Sweden live freely in the community - implemented a caseworker system, undertake needs assessment, inform asylum seekers of the process and explain their legal rights under Swedish law. Caseworkers also provide 'motivational counselling' preparing the asylum seeker for all possible outcomes and to assess risk of absconding - new model allows asylum seekers access to medical services, housing and work - detainees are encouraged to take an active role in their case, have access to the media and internet to research their case, also encouraged to contact NGOs - although the above initiatives are very supportive of asylum seekers, Sweden has the highest level of 'returns' (i.e. asylum seeker applications denied) in Europe, at over 80% - however, research shows that resettled refugees approved to stay in Sweden integrate quickly into the community, with no increased levels of welfare dependency or crime	
Vicary D, Searle G. Assessment and intervention with Kosovar refugees: design and management of a therapeutic team. *Australasian Journal of Disaster and Trauma Studies* 2000; 2. http://www.massey.ac.nz/~trauma/issues/2000-2/vicary.htm(last accessed December 03)	Describes needs assessment methods and subsequent interventions undertaken with Kosovar refugees in Australia in 1999	- focused on establishing a 'therapeutic presence' within a refuge establishment - chose a multidisciplinary team, with individuals who had experience in community development, torture and trauma, disaster management, cross cultural and language expertise, high level counselling skills and self-care strategies. - developed an approach which emphasised collaboration, dialogue, developing trust and an ethos of 'working together' - noted importance of providing adequate training and support to workers including information on Kosova, the war, and the people, as well as peer support strategies - focused on activity-based approach and programs that promoted psychological and physical resilience (and generally	

		not formal trauma therapy) - activities developed in response to 'needs' identified by the Kosovar community	

Table E.3.2: Collective trauma and violence experienced by Indigenous peoples – intervention options

Publication	Aim	Intervention details	Comments
Commonwealth Department of Health and Ageing. *Draft Consultation paper for the development of the national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional well-being 2004-2009*, 2003. Social Health Reference Group, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing ACT, Commonwealth of Australia http://www.health.gov.au/oatsih/pubs/pdf/sewb.pdf (last accessed Jan 2004)	Provides a detailed plan for mental health and social and emotional well-being for Indigenous people	- propose nine principles to guide better management of mental health issues among Aboriginal and Torres Strait Islander people, including: – holistic view of health, – self-determination, – culturally valid understanding of Indigenous peoples' health and mental health problems, – experiences and effects of trauma and loss, – human rights of Indigenous peoples, – ongoing stressors such as racism, stigma, environmental adversity and social disadvantage, – centrality of family and kinship, – multiplicity of Indigenous groups, languages, kinships and tribes, – respect for Indigenous peoples' strengths, creativity and endurance - mental health promotion focused on enhancing community capacity, strengthening families and building resilience of children and young people, by reducing risk factors and promoting protective factors - risk factors include harmful drug use, history of personal/family violence, socio-economic disadvantage, parental loss, physical or sexual abuse - protective factors include employment, supportive family, safe neighbourhood, connectedness to school and community feelings of personal worth and purpose - same risk and protective factors for mental health also relevant to other social outcomes such as substance misuse, violence, crime and school achievement - also significant issue that needs addressing is racism in non-Indigenous peoples and reducing systematic discrimination	- nine key result areas for mental health could benefit from a little restructuring, but elements are valid

		- specific examples of actions that could be taken for mental health promotion include: – preventing homelessness and preserving families, – preventing and responding to child abuse, – providing safe crime-free neighbourhoods, – improving education, income and employment outcomes, – building self esteem, connectedness and hope, – reducing racism, – building knowledge about mental health and encouraging help seeking - these initiatives will require partnerships across government, non-government and Indigenous groups; document gives specific examples of roles and responsibilities for each of these groups - document also outlines nine key result areas for improving Indigenous mental health including: – enhance resilience and protective factors for mental health with focus on children, young people and families, – reduce risk factors, especially grief, loss and trauma, – build up ACCHs and skilled workforce within ACCHs, – enhance capacity of mainstream mental health workforce and services to meet needs of Indigenous people, – enhance and coordinate funding – develop and publish culturally appropriate research and data relevant to Indigenous mental health and improved service delivery - implementation of these strategies will again require partnerships across sectors, more effective and collaborative service planning - document then takes each of the nine key area, and provides further details about specific actions that could be taken	
Kirmayer LJ, Simpson C, Cargo M. Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. Manuscript submitted to *Australasian Psychiatry*, 2003.	Identifies issues and strategies to guide development of culturally appropriate mental health promotion strategies with Aboriginal populations **in Canada**	- statistics show similar problems of individual and collective trauma, violence and loss as for Australia's Indigenous peoples; Canadian Aboriginals have incarceration rates 5-6 times the national average, 39% report family violence is a problem in their community, 25% report sexual abuse, 15% report rape, and youth suicide rates 3-6 times higher - problems linked to history of cultural oppression and forced assimilation, policies of child removal and multiple traumas associated with sexual abuse, emotional neglect, internalised	

		racism, language loss, substance abuse and suicide - present-day issues also implicated such as racism and ongoing actions by government, bureaucrats and professionals that undermine Aboriginal efforts at self-direction - note that workers in Aboriginal mental health must actively 'engage' in Aboriginal peoples' traditions and works to achieve "… an effective pluralism and hybridisation of models and methods in mental health care" (p.4) - authors emphasise importance of social and political events and argue that we should avoid 'psychologising' what are fundamentally political issues; **social origins of Aboriginal peoples' mental health problems require social solutions** - note that current trauma theory focuses on PTSD and pays insufficient attention to other effects of trauma and human rights abuses, e.g. issues of secure attachment and trust, belief in a just world, sense of connectedness to others, and stable personal and collective identity - strategies aimed at prevention and mental health promotion among Aboriginal peoples must focus on family and community as the primary locus of injury and source of restoration (rather than the individual in isolation)	
Malin M. Is *Schooling Good for Aboriginal Children's Health?* 2003. Casuarina NT: Cooperative Research Centre for Aboriginal and Tropical Health.	Relationship between social exclusion and health, and explores role of schooling as context for change	- "the current high levels of loss, traumatic and premature mortality, the separation of children from their families through family break-up and justice policies, plus continuing racism, disadvantage, and other effects of white colonisation, contribute to the present high level of stress (among Indigenous people)" (cited from Raphael and Swan 1997) - term "social exclusion" encapsulates the cumulative effect of colonisation on Aboriginal people, and includes economic hardship, levels of education and opportunities, and marginalisation - social exclusion argued to be the antithesis of social support, both of which are considered to be significant social determinants of health according to Brunner and Marmot (1999) - social exclusion limits peoples' access to resources, social networks and support; Aboriginal social exclusion evident in: lack of access to health services, a poor standard of living including inadequate housing and infrastructure, and experiences of racism - research confirms that social exclusion creates trauma and leads to deprivation which in turn generates stress (measured	- neither case study systematically evaluated

		as increase in cortisol levels) - some evidence that certain cultural factors can buffer the stress effects of social exclusion, racism, or immigration of minority cultural groups, eg. spirituality, a strong sense of cultural identity, family support, and association with members of one's own cultural community - national statistics on Indigenous student participation, retention and attainment rates indicate that mainstream schooling has not been successful in engaging them in learning (cited Beresford and Partington, 2003) - one possible explanation is that it is mainly the perceptions, life experiences, priorities and process of the dominant culture that informs school policy and programs; school is irrelevant to many Aboriginal children and their worlds - many Indigenous children experience direct blatant racist episodes in the school environment, as well as subtler more systemic forms of racism which operate to disadvantage them - author provides a case study of socially and academically supportive school environment in Darwin, and another program targeting Aboriginal children who would otherwise have dropped out of school and working with their families (brief details only)	
Minas H, Sawyer S. The mental health of immigrant and refugee children and adolescents. *MJA* 2002; 177: 404-405.	Editorial on McKelvey et al (2002) paper	- comment that low rate of identification of mental health issues by parents of their own children may hinder access to appropriate services - suggest that successful integration and acceptance of new arrivals in Australia associated with legal and policy frameworks that support multiculturalism, provision of extensive support services to assist immigrants and refugees, and the general goodwill of the Australian population towards immigrants and refugees - more recent policies likely to weaken support structures, create extra burdens on new asylum immigrants, and contribute to increases in mental health problems	- does not specify which policies have proved beneficial for refugees
Jones R, Masters M, Griffiths A, Moulday N. Culturally relevant assessment of Indigenous offenders: a literature review. *Australian Psychologist* 2002; 37: 187-197.	Discusses elements that need to be considered in programs designed to assist Indigenous people in correctional facilities.	- Noted that Indigenous peoples' social, political, economic and spiritual wellbeing have been systematically eroded over time - high rate of Indigenous incarceration (10-14 times the rate of other Australians) is a direct consequence of these changes - separation from land, family and culture has had an immeasurable impact upon Indigenous peoples' personal and emotional functioning including sense of identity; incarceration is yet another form of separation from land, family and culture	- article focuses on specific Indigenous subgroup (those in correctional facilities) and program aims to reduce reoffending; however the pathway for intervention is by way of enhancing

		- One study found over 50% of Indigenous offenders had one or more mental disorders (McKendrick et al., 1992) - Argue that correctional programs must address four key issues: – *Ethnocentrism*: need to recognise that the needs of people whose values and world views lie beyond one's own experience can be 'invisible'; Important to also acknowledge differences as legitimate rather than sources of deficiency; what is 'helpful' to non-Indigenous people is not automatically helpful to Indigenous people – *Recovery from colonisation*: need to recognise most Indigenous people are on a path of recovery from the effects of colonisation – *Distrust of government*: many Indigenous people feel hostile or distrustful of the majority culture in general, and justice and welfare agencies in particular; need to acknowledge and work with this distrust – *Guiding principles*: argue that should be explicit about values and principles that guide programs with Indigenous people; eg acknowledge the past, encourage reconciliation and power-sharing, equality before the law, recognition of cultural identity, rights to self-determination - Leading modifiable risk factors for Indigenous offenders are alcohol abuse and interpersonal conflict - unemployment (especially in rural/remote regions) is also an important risk factor; unemployed Indigenous people are incarcerated at 9 times the rate of non-Indigenous unemployed people, and 20 times the rate of employed Indigenous people - Obvious links between unemployment, alcohol abuse, and interpersonal conflict - Identify issues of 'deculturation' – loss of knowledge and connections to one's culture of origin – and 'acculturation' – process of adjusting to the majority culture which is different from one's own - Australian government's policies of assimilation aimed to achieve both deculturation and acculturation, and eradication of aspects of Indigenous culture not consistent with western values and norms - Argue that the stress on Indigenous people from these two processes are implicated in almost all other Indigenous needs, and underlie problems such as high rates of suicide, self-harm and crime	spiritual and cultural well-being - summary points listed here relate to more generic issues identified in the article

		- ***"fundamental remedies for many of the core personal and emotional needs of Indigenous people, including those related to acculturation stress … (include) empowerment, self-determination, strengthening of cultural norms and traditions"*** (p. 191) - programs must address individual risk factors and needs within the context of broader family and environmental concerns	
Vicary D, Andrews H. A model of therapeutic intervention with Indigenous Australians. *Australian and New Zealand Journal of Public Health* 2001; 25: 349-351.	Describes model for therapeutic intervention by mental health workers with Aboriginal clients	- model emphasises building trusting relationship with the Aboriginal community, family or individual (depending on who is the client) as the key to successful intervention - include concept of "cultural consultant" – a person who can advise on cultural appropriateness, ways of communicating, etc - model suggests presenting client with intervention options, describing strengths and weaknesses of each, and allowing client to select the intervention option they feel most comfortable with - provide case study of small Aboriginal community in north-western Australia with non-organic failure to thrive, linked to inadequate parenting and nutritional skills among young mothers and extend family	- note that case study is not specifically a "mental health" problem but early child development has important consequences for later physical and mental well-being
Devitt J, Hall G, Tsey K. *An Introduction to the Social Determinants of Health in Relation to the Northern Territory Indigenous Population*, 2001. Casuarina NT: Cooperative Research Centre for Aboriginal and Tropical Health.	Discussion of social determinant of Aboriginal health in the Northern Territory	- non-Indigenous research has shown that "… it is the level of control an individual has within their environment that determines whether the demands and stresses they experience have neutral, positive or negative consequences in terms of health" (p.2) - a corollary is that interventions should be aimed at developing skills that give individuals and groups an increased level of control over their circumstances; evidence exists that such interventions have been successful (e.g. Headstart program with African-American children) - research also shows that universal eduction is strongly predictive of improved health; education enhances peoples' skills as well as increasing their confidence to assert their will, and at least for some, challenge and modify existing social relations - social inequality and powerlessness have long been identified as key issues in Aboriginal wellbeing including health - history of losing control of land (frequently accomplished by personal violence, brutality and family dislocation) resulting in loss of economic base - achieving recognition of land rights is a necessary step on the	

		path to well-being: "the dispossessed are unlikely to achieve health" (p.6) - however, even where Aboriginal people have 'title' over their land, exercising control is not possible because many communities are themselves in crisis - research has consistently shown low levels of income for the majority of Aboriginal families; outright poverty is a major factor affecting health and well-being of Aboriginals - improved levels of Aboriginal engagement in the economy and society are unlikely without some change in current education and training outcomes - as Aboriginal groups strive for empowerment and reasserting control, "there remains considerable (perhaps increasing) resistance from those in authority and among the wider community to Aboriginal people managing their own affairs and to their attempts to influence the agendas of government, the corporate sector and community organisations" (p.8)	
Summerfield D. Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin* 2001; 25: 161-163.	Editorial questioning whether western psychiatry and 'talk therapies' are the appropriate methods to utilise with asylum seekers from non-western countries	- paucity of data on patterns of use of health services, including mental health services, by asylum seekers in the UK - questions the degree of 'fit' between mainstream mental health services and asylum seekers who come from non-western countries that are not familiar western psychiatry - assumptions by referring agencies that if asylum seekers come from a war torn area and have a history of exposure to trauma and torture they are candidates for a diagnosis of PTSD and therefore require psychological intervention - non-western cultures may find the reliance on 'talk therapies' quite foreign, when questioned about their needs the focus fell on work opportunities, schooling and family reunion - work has always played a major role in allowing 'refugees to resume the everyday rhythms of life and re-establish a viable social and family identity'	- highlights the cross-cultural issues faced when working with asylum seekers
Boughton B. *What is the Connection Between Aboriginal Education and Aboriginal Health?* 2000. Casuarina NT: Cooperative Research Centre for Aboriginal and Tropical Health.	Review of international research on impact of education on health, and explores relevance to Aboriginal health	- makes point that although we speak of Australian Aboriginals, this term masks local and regional differences, and different problems and different priorities and ideas about how to deal with them - research has shown that effect of school on health occurs, to some extent, independently of its effect on other social determinants of health, such as income and employment - however, the effect of education on health among Aboriginal Australians has not been systematically tested (nor in any other	

		first world country) - nonetheless, the author advocates interventions aimed at improving educational outcomes, such as strategies to improve attendance, researching links between bilingual education and better health, and research into effective mechanisms and consultation processes to increase Aboriginal influence and/or control of Aboriginal education policy and services - author also supports importance of 'sense of control' in determining health: "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health …" (cited from the Ottawa Charter, p.20) - we lack information about how people actually achieve that control and what kinds of education will most successfully help them to do so - noted that government officials regularly conflate self-management with self-determination	
Kirmayer LJ, Brass GM, Tait CL. The mental health of Aboriginal peoples: transformations of identity and community. *Canadian Journal of Psychiatry* 2000; 45: 607-616.	Summarises evidence for social origins of mental health problems in Canadian Aboriginals, and options for intervention	- high rates of depression, alcoholism, suicide and violence among Aboriginal Canadians linked to cultural discontinuity and history of systematic suppression and dislocation from land - by the end of 1960s, 30-40% of children who were legal state wards were Aboriginal (but only 1% were in 1959) - in addition to 'organised efforts' to destroy Aboriginal culture are added effects of poverty and economic marginalisation - mental health services and promotion must be directed at both individual and community levels, and consonant with Aboriginal realities, values and aspirations - note that the small size of most Aboriginal communities offers little opportunity for maintaining anonymity - argue that "…political efforts to restore Aboriginal rights, settle land claims and redistribute power through various forms of self-government hold the keys to healthy communities" (p.614)	

Table E.4.1: Collective trauma and violence (general) – evaluations of interventions

Publication	Aim	Intervention details	Comments
Rose S, Bisson J, Wessley S. Psychological debriefing for preventing post traumatic stress disorder (PTSD).	Describes systematic review of single session psychological debriefing following exposure to	- debriefing has been used in a wide range of circumstances eg. for police officers following shooting incidents, Red Cross personnel in humanitarian roles, medical students whose patients have died, rescue workers following natural disasters,	- articles mentions, in passing, four studies using more than a single session of cognitive

Cochrane Database of Systematic Reviews 2003, 3.	traumatic event	train drivers witnessing suicides, rape victims, etc - debriefing has two main aims: to reduce psychological distress after traumatic incident, and to prevent development of psychiatric disorders, usually PTSD - 11 trials included in review although overall quality of studies was poor - results showed that single session individual debriefing did not reduce psychological distress nor prevent onset of PTSD - one trial following up participants to one year showed an increase in risk of PTSD (odds ratio 2.33, 95%CI 1.11-7.53) among those receiving debriefing - conclude that there is no current evidence that psychological debriefing is a useful treatment for PTSD prevention after traumatic incidents - suggest that adverse results could be due to 'secondary traumatisation' from the debriefing event - debriefing assumes there is a uniform, and to some extent, predictable pattern of reactions to trauma, and that discussing the trauma is therapeutic, while attempting to deny it is not, but this is not true in every case; attempting to forget/distance oneself may be an adaptive response - recommend that "compulsory debriefing of victims of trauma should cease" - preliminary information suggests that delivering more formalised interventions over a longer period and aimed at those with overt distress may be worthwhile	behaviour therapy (CBT) treatment following traumatic event, which all showed beneficial effects - insufficient evidence to comment on group debriefing, debriefing with children, or multiple-session debriefing
Pedersen D. Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Social Science & Medicine* 2002; 55: 175-190.	Review of studies on the short and long-term impact of political violence	- wide repertoire of therapies (psychosocial and pharmacological) used to deal with trauma-related disorders but there is insufficient evidence supporting their effectiveness - no firm evidence that trauma counselling and debriefing works effectively, nor that interventions provided by humanitarian agencies provide something more valuable than what can be obtained from personal social support networks	
Norris FH, Friedman MJ, Watson PJ, Byrne CM, Diaz E, Kaniasty K. 60,000 disaster victims speak: Parts I and II. *Psychiatry* 2002; 65: 207-260.	Review of empirical literature on people involved in 'disasters', risk factors and levels of impairment, published between 1981-2001	- limited evidence that early intervention following disasters can help prevent longer-term problems - evidence is inadequate either to endorse or reject any specific approach - most intervention studies have examined effects of psychological debriefing; the majority of methodologically strong studies show that it does not prevent PTSD or other psychopathology and may even worsen psychological	

		symptoms - individual cognitive-behavioural treatments have received the strongest empirical support but with various qualifiers (eg not appropriate for extreme anxiety, suicide risk and acute bereavement reactions) - theoretically, for people with moderate levels of impairment, community interventions that can reduce stress, enhance social support and provide reassurance about future risk are advisable - for victims with more severe impairments, wide-spread professional mental health services are needed	

Table E.4.2: Collective trauma and violence experienced by Indigenous peoples – evaluations of interventions

Publication	Aim	Intervention details	Comments
Sibthorpe BM, Bailie RS, Brady MA, Ball SA, Sumner-Dodd P, Hall WD. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *MJA* 2002; 176:273-276.	Report on a failed RCT in an urban Aboriginal Medical Service (Adelaide).	- Brief intervention for hazardous **alcohol** use using an RCT. University investigators worked closely with AMS staff. - Study design involved screening clients for eligibility; assessing current alcohol use; obtaining consent; performing a blood test (optional); allocation to intervention or control group; doctor provides brief intervention (advice, education about hazardous alcohol use); if appropriate referral to Aboriginal Sobriety Group; follow-up in 6 months - Piloting testing showed only 16 clients recruited over 6 months, and trial terminated - Factors contributing to failure include: reluctance of clients to discuss their alcohol problems; reluctance of AHWs to ask about alcohol problems; inappropriateness of complex study protocols for busy Indigenous primary health care settings; and perception of no incentive for clients to participate. - Commented that "'gold-standard' RCT-derived evidence for the effectiveness of many public health interventions in Indigenous primary health care settings may never by available, and decisions about appropriate interventions will often have to be based on qualitative assessment of appropriateness and evidence from other populations and settings"	
Maclean SJ, D'Abbs PHN. Petrol sniffing in Aboriginal communities: a review of interventions. *Drug and Alcohol Review* 2002; 21: 65-	Review of interventions used for petrol sniffing among Aboriginal communities, and their outcomes	- little documented information about the nature and combination of interventions that are most effective in addressing petrol sniffing and other forms of inhalant misuse - reviewed published and unpublished literature relevant to petrol sniffing in Aboriginal communities	

72.		- ages ranged from 8 to 30 years; ratio of males to females is around 3:1; early intervention more effective than treating longer term users - argue that interventions should address 'drug' (i.e. pharmacological properties of the drug), 'set' (mental and physical attributes of the user) and 'setting' (environment in which it occurs) - very few interventions in Australia have been evaluated, so attempting to determine effectiveness tends to rely on observation and 'impressions' - interventions classified into primary (prevention), secondary (treatment) and tertiary (chronic sufferers) *Primary* - recreation programs have been part of most successful campaigns: should comprise wide range of activities for males and females; should be provided during after-school hours, evenings, weekends and school holidays; should provide opportunities for risk-taking; should be relatively informal and unstructured - educational options limited by poor educational standards among many Aboriginal youth, especially in rural and remote regions; authors suggest it may have a role in supporting communities to develop coping capacities, and as adjunct to other interventions - interventions which focus on the substance itself – e.g. restricting supply – found to be ineffective unless accompanied by other measures that address set and setting *Secondary* - two major attempts: one focused on providing family counselling and education (HALT), and the other on encouraging community action against petrol sniffing (Petrol Link-up); mixed success - banning sniffers to 'outstations' where they receive care and attention from family and community members has also proved effective, but most sniffers will resume if complementary changes are not made in the home community *Tertiary* - majority of care of chronic and disabled sniffers falls to families - little evidence supporting efficacy of residential rehabilitation programs *Summary*	

		- little evidence that single-measure strategies have significant impact - communities cannot work alone, and need support from government for evidence-based interventions and funding, and commitment to funding proper evaluations "with the objective of improving service delivery and not as a means of exercising bureaucratic control" (p.70) - argue that 'best buys' are likely to be in creating recreational, educational and employment opportunities	
Gray D, Saggers S, Sputore B, Bourbon D. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction* 2000; 95: 11-22.	To identify intervention strategies that have been effective in reducing excessive alcohol use among Aboriginal groups	- identified a broad range of intervention strategies, including treatment programs based on Alcoholics Anonymous or abstinence principles; health promotion through education and information; 'night patrols' and sobering up shelters, and 'dry' communities - few have been systematically evaluated, and evaluation methodologies had weaknesses - impact of most interventions that have been evaluated appears limited, but this may be, in part, due to inadequate resourcing and program support. - some suggestion that supply reduction strategies may be effective. - pressing need for more rigorous evaluation studies.	- authors note that projects with Aboriginal peoples made more complex by broader political context, including issues such as self-determination and financial and social accountability, ability of both community and government agencies to conduct adequate evaluations, and use of culturally appropriate methods.
Morris PS. Randomised controlled trails addressing Australian Aboriginal health needs: a systematic review of the literature. *Journal of Paediatric Child Health* 1999; 35: 130-135.	Describes the frequency and design of controlled clinical trials addressing the health needs of Aboriginal Australians	- systematic review of RCTs with Aboriginal samples; identified 13 studies between 1970 and 1997 - only 2 of the 13 papers were published in the last 10 years (both in 1996), and 11 of the 13 papers involved studies with children only. - no study included mental health indicators per se - author concludes there is a profound lack of well-designed studies assessing medical interventions	- paper focuses on medical interventions based on RCT design - results of this review plus the more recent paper by Sibthorpe et al (2002) confirm that this 'style' of research has not been used extensively (or successfully) with Australian Indigenous samples.

TABLE F – INTERPERSONAL VICTIMISATION

Table F.1.1: Interpersonal victimisation (general) – definitions

Publication	Concept	Definition	Comments
Emery RE, Laumann-Billings L. An overview of the nature, causes, and consequences of abusive family relationships. *American Psychologist* 1998; 53: 121-135.	family maltreatment family violence	- maltreatment: minimal physical or sexual harm or endangerment - violence: serious physical injury, profound psychological trauma, or sexual violation	- authors note that conceptualisation of violence or abuse is inherently driven by social judgement and agreed definitions are difficult

Table F.1.2: Intimate partner violence – definitions

Publication	Concept	Definition	Comments
Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal of Family Violence* 1999; 14: 99-132.	intimate partner violence (IPV)	- includes two components: 'violence' defined as involving physical force or intent to cause physical pain; and 'intimate partner' current or former husbands, unmarried domestic partners, and other intimate partners - psychologically abuse behaviours are not included in this definition	

Table F.1.3: Peer victimisation (bullying) – definitions

Publication	Concept	Definition	Comments
Smith PK, Ananiadou K. The nature of school bullying and the effectiveness of school-based interventions. *Jnl of Applied Psychoanalytic Studies* 2003; 5: 189-209.	bullying	- subset of aggressive behaviour, characterised by repetition and by an imbalance of power - main types of bullying: physical, verbal, social exclusion, indirect (e.g. nasty rumours) - traditional 'roles' in bullying include: bully, victim, bully-victim (i.e. both), reinforcer, defender, bystander	
Rigby K. *A Meta-Evaluation of Methods and Approaches to Reducing Bullying in Pre-Schools and Early Primary School in Australia*, 2002. Canberra: Commonwealth Attorney-General's Department. www.crimeprevention.gov.au (last accessed Dec 2003)	bullying	- noted that there is no 'standard' definition, but studies tending to converge on the following elements of bullying - a distinct form of aggressive behaviour; - occurs in situations in which aggressive behaviour is being deliberately practices by a person or group more powerful than the individual(s) being targeted; - it is seen as unjustifiable behaviour; - it typically involves repeated behaviour; and - the action is experienced by the target as oppressive and by the perpetrator as enjoyable - various estimates from empirical studies suggest approximately 16-18% of children aged 5-8 yrs were classified as victims	
Lindström P. School violence: a multi-level perspective. *International Review of Victimology* 2001; 8: 141-158.	bullying school violence	- bullying - repeated, negative actions over time, including hitting, kicking, threatening, locking inside a room, saying nasty and unpleasant things, and teasing (from Farrington, 1993) - bullying typically excludes fights between two students of similar physical strength - school violence – physical attack from someone at school by means of hitting or kicking that hurt	
Hawker DSJ, Boulton MJ. Twenty years' research on peer victimisation and psychosocial maladjustment: a meta-analytic review of cross-sectional studies. *Journal of Child Psychology & Psychiatry* 2000; 41: 441-455.	peer victimisation	- the experience among children of being a target of the aggressive behaviour of other children - several types of victimisation including: *physical victimisation* – any form of victimisation in which the victim's physical integrity is attacked; *verbal victimisation* – victimisation in which the victim's status is attacked or threatened with words or vocalisations; *indirect victimisation* – aggression which is enacted through a third party or so that the aggressor cannot be identified by the victim; *relational victimisation* – behaviour which causes, or threatens to cause, damage to peer relationships, and particularly to friendship and acceptance	

Table F.2.1: Interpersonal victimisation (general) – associations with mental health

Publication	Aim or research question	Summary	Comments
OECD, WHO. *DAC Guidelines and Reference Series: Poverty and Health*, 2003. OECD: Paris, pp. 53-66.	Summary of policy issues to improve the health of the poor	- poor women and girls especially vulnerable to physical, sexual and psychological violence including rape, genital mutilation, forced marriage and prostitution, widow abuse, neglect of elderly women, and murder (both of female infants and young women) - direct consequences of interpersonal violence include injury, ill health and death	
Shaw BA, Krause N. Exposure to physical violence during childhood, aging and health. *Journal of Aging and Health* 2002; 14: 467-494.	Nationwide sample of adults aged 25-74 who had been exposed to physical violence in childhood Paper includes review of literature on harmful effects of exposure to trauma	- violence conceptualised as a specific type of trauma that primarily affects individuals in isolation i.e. 'micro-level trauma' - authors point out there is far more research on childhood sexual abuse than childhood physical violence yet in a recent community based study of almost 10,000 people, found 26% reported being victims of childhood physical violence vs 8% having experienced childhood sexual abuse - study focused on acts of physical violence administered by parents towards their children - much of existing research has focused on immediate or short-term effects of exposure to childhood violence such as childhood violence or psychosocial adjustment; more recently interest in longer term effects of traumatic events - MIDUS survey in USA conducted in 1995; 2,788 people in the total sample reported childhood physical violence - risk factors for childhood violence were male gender, lower education and non-white race - childhood physical violence associated with elevated levels of depressive symptoms during adulthood, presence of more chronic health conditions, presence of heart trouble but not cancer, high BP or diabetes - childhood physical violence associated with lower sense of personal control in adulthood, less emotional support and more negative interactions with family and friends - sense of personal control, and emotional support and interactions with family (but not friends) strongly associated with depressive symptoms, and explain nearly 75% of variation between childhood violence and adult psychological health - similarly, sense of personal control strongly, and negative interactions with family associated with adult physical health, and explain 43% of variation between childhood violence and	- acknowledge that study relies on memories of childhood violence from adults, which are open to error - sample was restricted to children who had both a mother and father figure while growing up, so generalisability of results not clear - data are cross-sectional so that conclusions about effects over time need to be substantiated with longitudinal studies

		adult physical health - conclude that people exposed to physical violence in early life more likely to have both psychological and physical health problems throughout adulthood - importantly, the effects do not appear to diminish with age - a sense of personal control and social relationships with one's family seem to be important mediators	
Bennett LR, Manderson L, Astbury J. *Mapping a Global Pandemic: Review of Current Literature on Rape, Sexual Assault and Sexual Harassment of Women*, 2000. Geneva: WHO Global Forum for Health Research.	Review of literature published since 1995, on sexual violence against women	- growing evidence that the relationship between sexual violence, and depression and post-traumatic stress disorder for women is causal - sexual violence against women predominantly by known perpetrators	- research on violence and health outcomes is predominantly quantitative (surveys), and weighted towards the USA, rape and convenience samples of women in tertiary institutions - little rigorous evaluation of interventions (e.g. counselling) or preventative strategies (e.g. mass media campaigns, educational programs in secondary schools or universities, or for staff in medical settings) - fundamental problem that 'visible' episodes of violence only a small proportion of all violence against women
World Health Organization. *Women's Mental Health: An Evidence Based Review*, 2000. Geneva: World Health Organization.	Evidence-based review	- violence against women is overwhelmingly likely to be perpetrated by someone known intimately to the woman - one fifth to one third of women will be physically assaulted by a partner or ex partner during their lifetime - violence against women at work is emerging as a significant problem but data are limited - wide variation in rates of violence against women in different countries suggests potentially modifiable cultural factors important in determining actual rates of violence and attitudes towards its acceptability	- wide range of terminology used to describe violence against women eg. Spouse abuse, wife abuse, intimate partner violence, gender based violence, sexualised violence, domestic violence and family violence

		- experience of violence associated with increased rates of depression, anxiety, stress-related syndromes, substance abuse, suicidality, somatic and physical symptoms, negative health behaviours and poor subjective health - strong association between child sexual abuse and physical, sexual and psychological (especially depression and anxiety) problems in adulthood - child sexual abuse tends to coexist with other factors detrimental to mental health e.g. disrupted unstable home environment, conflict, etc - also victims of child sexual abuse 2-4 times more likely to be raped in adulthood - "violence can further weaken women's social position by operating on structural determinants of health such as employment and by implication, income at the same time as increasing their psychological vulnerability to depression and other disorders (p.90) - large body of research indicates the importance of social support and having a confidant in relation to depression associated with violence	- strategies for women who are at risk of, or victims of violence, should include efforts to reduce social isolation, enhance women's social support networks and increase access, ensure adequate, affordable and accessible community services, and guarantee that women have safe workplaces
Emery RE, Laumann-Billings L. An overview of the nature, causes, and consequences of abusive family relationships. *American Psychologist* 1998; 53: 121-135.	Focus on child abuse but also includes spousal, sibling and elder abuse	- distinction between family maltreatment vs family violence (see definitions above) - three primary sources of information about family violence: official statistics; information gathered by professionals who come into contact with victims; and population sample surveys - these three types of studies yield widely divergent results - definition of violence affects prevalence estimates e.g. inclusion of spanking of children would increase rates enormously - considerable overlap between spouse abuse and child abuse - family violence needs to be conceptualised within a family systems framework but also broader ecological perspective; violent families tend to live in communities with higher rates of community violence - relationship between poverty, high unemployment, inadequate housing, social isolation and child mistreatment is well established - family violence also perpetuated by broader cultural beliefs and values such as the use of physical punishment and violence in the popular media - consequences of violence are a function of five broad groups of variables:	

		1. nature of the abusive act (including frequency, intensity and duration); 2. individual characteristics; 3. relationship between victim and perpetrator; 4. response of others to the abuse; and 5. factors that can exacerbate the effects of abuse eg family chaos. - evidence indicates that all types of family violence are linked with diverse psychological problems including aggression, anxiety and depression - some forms of abuse more strongly associated with some types of problems eg. rape and PTSD, child sexual abuse and sexually inappropriate behaviour - consequences of violence can be ongoing and long term, and unfold over time	

Table F.2.2: Intimate partner violence – associations with mental health

Publication	Aim or research question	Summary	Comments
Coker AL, Davis KE, Arias I, Desai S, Sanderson M, et al. Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine* 2002; 23: 260-268.	Population based study using data from the National Violence Against Women Survey to investigate health effects of intimate partner violence (IPV) for men and women	- telephone survey of 6,790 women and 7,122 men - 28.9% women and 22.9% men reported physical, sexual or psychological IPV during their lifetime - lifetime prevalence of physical IPV alone was 13.3% for women and 5.8% for men; sexual IPV alone was 4.3% for women and 0.2% for men; and psychological IPV alone was 12.1% for women and 17.3% for men - almost half of the IPV among women and >78% of IPV among men was psychological IPV, which is often not included in IPV studies - strongest risk factor for IPV was being physically assaulted as a child (both men and women) - all forms of IPV significantly associated with current depressive symptoms (men and women) - physical and psychological IPV associated with heavy alcohol use and 'therapeutic' drug use - women experiencing IPV more likely to report poor physical and mental health	- some of the victims of IPV also perpetrators, particularly among the men - reaffirm recommendations for screening for IPV victimization among women to include physical, sexual and psychological abuse - no such recommendations yet exist for identifying and treating male victims of IPV, and needs further work
Astbury J. *Gender Disparities in Mental Health*, 2201. World Health	Summary of evidence on prevalence rates, risk factors, correlates and consequences	- intimate partner violence, especially against women, tends to be repetitive and escalate in severity over time, and comprise three key features strongly linked to depression in women:	- mental health impact of women involved in sexual trafficking has not

Organization Ministerial Round Tables.	of gender disparities in mental health	humiliation, enforced inferior ranking and subordination, and blocked escape or entrapment - physical, sexual and psychological violence all linked to high rates of depression and comorbid psychopathology	been assessed
Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal of Family Violence* 1999; 14: 99-132.	Review of literature on prevalence of mental health problems (specifically depression, suicidality, PTSD, alcohol or drug abuse and/or dependence among women with a history of intimate partner violence (IPV)	- evaluated the strength of evidence using criteria proposed by Hill (1965), based on the premise that associations are generally more likely to represent causation if they are large than if they are small - for this review, IPV restricted to violence by men against women - 18 studies on IPV and *depression* showed mean prevalence of depression among battered women was 47.6% (general population rate 10.2%) - 13 studies on IPV and *suicidality* showed mean prevalence of suicidality among battered women was 17.9% (general population rates of 0.8%-15.9% for ideation and 0.1%-4.3% for attempts) - 11 studies on IPV and *PTSD* showed mean prevalence of PTSD among battered women was 63.8% (general population rates 1.3-12.3%) - 10 studies on IPV and *alcohol abuse/ dependence* showed mean prevalence of alcohol abuse/dependence among battered women was 18.5% (general population rate 4.6-8.2%) - 4 studies on IPV and *drug abuse* showed mean prevalence of drug abuse among battered women was 8.9% (general population rate 4.8-5.9%) - dose-response relationship including severity or duration of violence associated with prevalence or severity of depression and PTSD	- absolute prevalence rates for all mental health problems did not demonstrate consistency across studies, and varied with the sample used - studies have not systematically evaluated ethnic or cultural differences among battered women and mental health outcomes

Table F.2.3: Peer victimisation (bullying) – associations with mental health

Publication	Aim or research question	Summary	Comments
Anonymous. Bullies and their victims. *Harvard Mental Health Letter* 2001; 18: 4-6.	Summary of current knowledge about bullying at school	- bullying includes the repeated taunting, harassment, intimidation and humiliation of children who cannot defend themselves, thus bullying is an abuse of power - sometimes there is an underlying threat of physical violence - among girls a more subtle indirect form of harassment is common; social manipulation through spreading gossip, telling malicious lies, betraying confidences, passing nasty notes, excluding from group activities, etc	

		- victims are usually smaller, younger, weaker, outnumbered or simply less confident and popular - bullying is common; in a recent USA survey almost one-third of students admitted to being involved in bullying in some way – 13% as bullies, 11% as victims, and 6% as both - bullying is more common among boys, and is most serious in early adolescence (11-14 yrs) - boys who are homosexual or believed to be homosexual constitute a special class of victims - victims of bullying tend to learn how to cope as they grow older while bullies tend to remain aggressors but victims tend to have higher than average rates of depression even in the longer term	
Bond L, Carlin JB, Thomas L, Rubin K, Patton G. Does bullying cause emotional problems? A prospective study of young teenagers. *BMJ* 2001; 323: 480-484.	Examines relationship between bullying and self-reported symptoms of anxiety or depression in secondary school students in Victoria	- authors note that studies of the effects of peer victimisation have generally focused on primary school children, before the early increase in depression in adolescence - this prospective study assessed victimisation in Year 8, and then examined mental health in Year 9;also considered potential contributing factor of availability of attachments (trusting relationships) and conflictual relationships (arguments with others) - prevalence of history of victimisation in Year 8 was 51%; incidence of self-reported depression or anxiety in Year 9 was 7%; students with history of victimisation were 2.3 times as likely to be depressed (95%CI 1.2-4.3) - after statistical adjustment for demographic and relationship factors, victimisation remained predictive of anxiety or depression in girls but not boys - previous emotional problems were not significantly related to future victimisation, indicating that mental health factors followed rather than preceded victimisation	- although not explored by authors, the non-significant result for boys could possibly be explained by the effects of victimisation on boys' mental health being other than anxiety or depression e.g. more acting out behaviours
Lindström P. School violence: a multi-level perspective. *International Review of Victimology* 2001; 8: 141-158.	Overview of evidence about school violence in Sweden	- previous research has shown that prevalence estimates vary depending on how questions are defined and formulated, and the sample selected - these issues make comparisons between studies difficult, and also explain wide variations in prevalence rates across studies - a national survey in Sweden found 12-14% of boys and 4-5% of girls reported being victimised - 4-5% of boys and 1% of girls reported being victimised by school violence for which they needed some form of treatment (i.e. more extreme form of bullying) - victims and perpetrators more likely to be boys	- generalisability of results in Sweden not known - wide variation in prevalence rates across schools not all due to measurement differences – suggest that school violence can be reduced

		- students in urban schools at increased risk, although across urban schools rates vary widely - victims tend to have low self-esteem, be unpopular, have few friends, have poor social support networks with peers and teachers, have slightly lower school attainment - perpetrators of school violence tend to have low school involvement, and to engage in delinquent acts (e.g. shoplifting, using illicit drugs, smoking, drinking) - schools in lower SES and socially unstable neighbourhoods were three times more likely to have police recorded violent crime - clearly some schools have more trouble with violence than others; in most violent school 30% of students indicated being victimised, least violent school about 8% (mean=15%) - schools with high violence rates also tend to have problems with vandalism, theft, burglary, arson, etc - overall conclusion that schools where social capital is low, violence tends to be higher, especially among students with low self-esteem and weak school involvement	
Hawker DSJ, Boulton MJ. Twenty years' research on peer victimisation and psychosocial maladjustment: a meta-analytic review of cross-sectional studies. *Journal of Child Psychology & Psychiatry* 2000; 41: 441-455.	Review of cross-sectional studies published between 1978-1997	- despite identification of subtypes of victimisation (see definitions above) in most studies subtypes were not assessed separately; rather victimisation tended to be measured as a composite of two or more types - victimisation also most commonly assessed by self-report or peer-report - psychosocial maladjustment usually measured by self-report - results showed that victimisation is most strongly related to depression and least strongly related to anxiety - mean effect size for depression r=0.45, for loneliness r=0.32, for anxiety r=0.25, for low self-esteem r=0.39, for poor self-concept r=0.35 - conclude that victims of peer aggression experience more negative affect and negative thoughts about themselves than other children - consistent finding using a variety of research methods and participants drawn from diverse populations, and across both sexes and all age groups - authors argue there is no need for more of this kind of research; time to move on and do other research (eg. causation, differences across subtypes, intervention options)	- few studies looked at relational or indirect victimisation

Table F.2.4: Young people – associations with mental health

Publication	Aim or research question	Summary	Comments
Raphael B. *Promoting the Mental Health and Wellbeing of Children and Young Peop*le, 2000. Canberra: Department of Health and Aged Care.	Discussion paper on strategies for working collaboratively towards comprehensive and effective services to support the mental health and wellbeing of Australian children and young people	- paper cites findings from first national Australian survey of mental health and wellbeing; found approximately 14% of children and young people (4 to 17 yrs) had mental health problems; considered a valid but probably conservative estimate - children and young people living in sole-parent, step/blended or low-income families, or with unemployed parents, or in metro (rather than rural) locations were more likely to have mental health problems - important to remember that this survey data cannot determine if demographic characteristics are causal, but indicate need to target socially disadvantaged communities - depression reported for approximately 3.7% of all children, and 4.8% and 4.9% in males and females aged 13-17 yrs respectively - attention deficit disorder identified in 19.3% of boys and 8.8% of girls aged 6-12 years (relatively high rates raise some questions about definition of ADD used in the survey) - children with mental health problems also had lower self-esteem, and functioned less well in school and peer activities - other research shows that many mental health problems that occur in childhood continue into adult life, including increased risk of adult mental health disorders, death, delinquency, crime, unemployment and homelessness - critical risk factors for mental health problems in children and young people are: problems of biological immaturity; unstable relationships with parents and carers; death of a parent; inadequate parenting skills; poor quality child care; family discord (violence, parental separation, family breakdown; sole parenting; parents with serious physical and mental health problems; lack of social support; psychological trauma, physical illness or disability; lack of peer support; involvement in deviant peer groups; adverse change in the broader society; and poverty (p.17)	

Table F.3.1: Interpersonal victimisation (general) – intervention options

Publication	Aim	Intervention details	Comments
Emery RE, Laumann-Billings L. An overview of the nature, causes, and consequences of abusive family relationships. *American Psychologist* 1998; 53: 121-135.	Focus on family violence	- argue different levels of abuse influence type of intervention needed (i.e. supportive vs adversarial) - important to note that some interventions can have tremendously adverse effects on children and families eg removal of children and placement in foster care - criticism of current system of reporting cases to child protection services; suggest shift towards supporting rather than policing families under stress, but at the same time pursuing more vigorously cases of serious family violence - supportive interventions include individual and group therapies, parent-training and family therapy, home-visiting programs to prevent child abuse - in general, the more serious and chronic the abuse, the less successful the intervention program - home visitor prevention programs for high-risk parents that simultaneously assist with material, psychological and educational needs shown to be effective	

Table F.3.2: Peer victimisation (bullying) – intervention options

Publication	Aim	Intervention details	Comments
Vernberg EM, Gamm BK. Resistance to violence prevention interventions in schools: barriers and solutions. *Journal of Applied Psychoanalytic Studies* 2003; 5: 125-137.	Describe 'core set' of potential barriers to addressing bullying behaviour in schools	- argue that multiple factors exist at different levels (e.g. culture, community, school, individual) that can limit/impair use of school-based approaches to bullying - basic requirement for 'coming together' of people at these different levels, united by common values, beliefs and attitudes - factors at cultural level: – many cultures/subcultures view behaviours such as ostracism, intentional humiliation and corporal punishment as acceptable – some children experience or witness intimidation, ridicule or aggressive behaviour by their parents and learn that it is acceptable to use similar methods to control others	- school-based intervention programs on bullying have generally included aspects of cultural influences and norms, but only within the school context - this paper suggests engagement and intervention is needed for the wider context - paper does not include 'family' as one of its specific levels, but this would seem of value - paper also does not

		– in some cultures, aggression is actively encouraged as a means to solve problems or as a response to perceived disrespect – bullying and victimising behaviours towards minority groups may be encouraged or tolerated – in many societies, cultural norms value 'tough, strong' and belittle 'weak victims' i.e. social Darwinism and survival of the fittest argues against protecting individuals with less desirable qualities – cultures may 'condone' bullying as part of growing up, and teaching children how to be tough – cultures may 'blame' victims of bullying as having done something to cause their troubles - changes in attitudes and beliefs about bullying are unlikely to occur without extensive consideration of these contextual factors - factors at community level: – support from local government and business is needed to provide financial support, volunteers for roles such as mentors or monitors, and political support - factors at community level: – teachers and school administrators need to see their roles and responsibilities more widely than educational, i.e. also fostering children's physical and emotional well-being, and that teachers and administrators can and should serve as agents of violence prevention, and ensuring a safe and secure learning environment – research on prevention efforts strongly suggest that principals need to be involved in change strategies, and actively supported by other staff – helpful to provide frequent feedback/indicators of improvement to sustain momentum and motivation – prevention and intervention programs can fail because of inadequate training and support provided to teachers and staff – programs can also fail because of other inadequate resourcing (time, money, etc)	consider individual child factors, rather it focuses on individual teacher factors

		– it can be difficult to see changes in children's behaviour if they have been 'labelled' as victims or bullies (this can apply to teachers as well as students); children who do not receive recognition and acknowledgement for changes can readily revert to their former 'maladaptive' behaviours - factors at individual level: – individual teachers and school administrators have different attitudes about bullying and will vary in their willingness and ability to participate in anti-bullying activities	
Neser JJ, Ovens M, van der Merwe E, Morodi R, Ladikos A. Peer victimisation in schools: predisposition to, reasons for and measures against this prevalent phenomenon. *Crime Research in South Africa* 2003; 5 (1). www.crisa.org.za/predisp.pdf (last accessed 21 Jan 2004)	Descriptive study of bullying behaviours among 220 students in South Africa	- study is small and not overly informative to the VicHealth project, however paper cites a book by Brewster and Railback (2001) that identifies "..the following seven steps to addressing bullying through strategies to promote a positive school ethos": – assess the school's needs and goals, – develop an anti-bullying policy, – provide training for teachers, administrators and other staff, – involve parents, – identify resources for bullies, victims and families, – provide increased supervision in areas where bullying tends to occur, and – integrate anti-bullying themes and activities into the curriculum	- possibly an 'obvious' and simplistic checklist, but could be included as a component of a range of strategies and checklists
American Medical Association. *Report 1 of the Council on Scientific Affairs, (A-02). Bullying Behaviors Among Children and Adolescents*, 2002. www.ama-assn.org/ama/pub/category/3945.html (last accessed 23 Jan 2004)	Medline review to identify scope of bullying among US children and adolescents, and successful interventions in order for make policy recommendations to AMA	- review of English-language published articles between 1985-2002 in Medline - found bullies represent 7-15% of sampled school-age children, victims represent about 10%; prevalence decreases during junior high and continues to decrease into high school - without intervention, bullying can lead to serious academic, social, emotional and legal problems - studies of successful anti-bullying programs in USA are scarce, but evaluations from other countries suggest student behaviours can be changed - recommendations made to AMA include: recognise potential serious social and mental health consequences from bullying for children and adolescents; and urge physicians to be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents, for physicians to enhance their awareness of the social and mental health consequences of bullying, and to screen for psychiatric co-	

		morbidities in at-risk patients	

Morrison B. Bullying and victimisation in schools: a restorative justice approach. *Australian Institute of Criminology; trends & issues in crime and criminal justice (series)*, 2002, No. 219 www.aic.gov.au	Reports on a restorative justice pilot program run in a primary school in the ACT	- 'restorative justice' form of conflict resolution and seeks to make clear to the offender that his/her behaviour is not condoned, while at the same time being supportive and respectful of the individual - program developed in the ACT, called Responsible Citizenship Program, for primary school children, based on five principles: – bullying and being bullied are ways of behaving that can be changed, – addressing wrong-doing, such as bullying, concerns actions and should not involve denigration of the whole person, – harm done by bullying to self and others must be acknowledged, – reparation for the harm done is essential, and – both bullies and victims are valued members of the school community whose supportive ties with others should be strengthened through participation in communities of care - program delivered to Year 5 students, 1 hour twice a week over 5 weeks (total 10 hrs) - evaluation results showed students' feelings of safety within the school increased over the year; reduction in the proportions of students who used 'victim' and 'bully' types of behaviours	- small study, quite different from majority of existing anti-bullying programs
Anonymous. Bullies and their victims. *Harvard Mental Health Letter* 2001; 18: 4-6.	Summary of current knowledge about bullying at school	- suggest intervention with bullies should include teaching self-control, learning to see the perspective of others, behaviour modification, and enforcement of sanctions such as loss of privileges - evidence suggests group treatment of bullies is usually ineffective, but groups of victims may benefit from shared experiences and support - victims also need to be taught to speak up (victims rarely tell teachers, more often family or friends) - schools also need to accept bullying as a school responsibility, and promote climate where bullying is not tolerated - other school initiatives include training teachers, monitoring by teachers, class discussions, role playing and games that help students be more aware of the harm caused, support for victims, and consistent enforcement of sanctions	
Hawkins DL, Pepler DJ, Craig WM. Naturalistic observations of peer	Examines behaviour of 58 children in bullying incidents in school playground,	- note that peers are present in the vast majority of bullying episodes (around 85%), and therefore have the potential to counteract bullying by intervening	

interventions in bullying. *Social Development* 2001; 10: 512-527.	focusing on intervention behaviour by peers	- present study examined frequency, duration, nature and effectiveness of peer interventions in bullying incidents - study implemented in two elementary schools in Toronto, Canada with children aged 6-12 years (grades 1-6) - sample of 58 children and 306 bullying episodes recorded on video - found peers were present during 88% of bullying episodes, boys were more frequently present than girls - peers intervened in 19% of bullying episodes, no difference between boys and girls; 57% of these interventions were effective in stopping the bullying episode - interventions were more likely to be directed at the bully and more likely to be aggressive, although aggressive and non-aggressive strategies were equally effective in stopping bullying episodes - authors recognised that this is a small, naturalistic observation study and therefore has several limitations e.g. could not examine systemic factors, could not control for demographic factors, sample comprised twice as many boys as girls	
Lindström P. School violence: a multi-level perspective. *International Review of Victimology* 2001; 8: 141-158.	Overview of evidence about school violence in Sweden	- argues that there is no evidence to support effectiveness of interventions that provide broad information and training to bullies about negative physical and social consequences of violence - suggests a multi-agency coalition consisting of school personnel, students, parents and representatives of the local community (e.g. police, social authorities) to work together to develop local solutions	
Osofsky HJ, Osofsky JD. Violent and aggressive behaviours in youth: a mental health and prevention perspective. *Psychiatry* 2001; 64: 285-295.	Summarises three prevention and early treatment programs for youth violence	- in the majority of cases of juvenile victimisation, the perpetrator is a family member or acquaintance rather than a stranger - considerable variation across countries and regions in prevalence of youth violence - risk factors include family violence, mental illness, parental depression, poor parenting skills, immaturity, adolescent parenting, parents with little education, and family disruption - at risk families tend to be isolated with little support, substance abusing, poor and lack empowerment on behalf of their children - protective family factors include strong relationships among family members, supportive extended family system, religiosity, and good health habits - systemic community-based programs and after-school programs have demonstrated significant success in reducing	- not specific to school bullying, but rather violence among youth

		juvenile crims and violence, reducing drug use and addiction, reducing teen sex and pregnancy, and boosting school success and high school graduation - three intervention programs involving mental health professionals - *Violence Intervention Program*: developed in New Orleans in 1992, systems approach working with whole community to solve problem of youth violence; combination of early intervention, counselling, 24 hr hotline, services to victims, education and prevention forums directed at police, parents, schools, and children. Also developed specific summer activities for youth during holidays – police reported drop of 45% in juvenile crime in first year, and 55% in second year. - *Youth Leadership Program*: after-school and Saturday diversionary program for high-risk boys aged 13-16 yrs with disruptive or truant behaviour, or non-violent crimes. Program addresses violent or aggressive behaviour patterns (conflict resolution, anger management, etc), provides academic enrichment, improves leadership skills, increases community awareness, and improves relationships with parents, teachers and peers. - *Prevention and Evaluation of Early Neglect and Trauma (PREVENT)*: court-based and court-created prevention and intervention for young children and families, where children are maltreated or exposed to violence. Program aims to identify and intervene with high-risk infants and toddlers and their families to support child development, bonding, attachment and reduced abuse and neglect.	
O'Connell P, Pepler D, Craig W. Peer involvement in bullying: insights and challenges for intervention. *Journal of Adolescence* 1999; 22: 437-452.	Examines peer process during bullying episodes in the school playground	- noted that there is considerable continuity between aggressive behaviour during childhood and adolescence; involvement in bullying during pre-adolescence may subsequently evolve into gang activity with aggressive peers, antisocial and other problem behaviours - bullying is systemic and unfolds in a set of social contexts: dyad, peer group, playground setting and school environment - authors used social learning theory to examine patterns of modelling and reinforcement - modeling behaviour is more likely when: the model is a powerful figure; the model is rewarded rather than punished for the behaviour; and the model shares similar characteristics with the observer – all conditions are often met between bullies and	- this study part of same research work reported above by Hawkins et al., 2001 - study is again limited by small size, and being primarily observational/descriptive

		peers - examined 53 segments of video tape of bullying behaviour in the playground with students in two elementary schools in Toronto, Canada - results showed that peers' usually present during bullying episodes and peer behaviour often reinforces bullying behaviour - show that intervention programs that target the bully or the victim are inadequate; larger goal of intervention is to reduce the bully's influence on the audience and help peers perceive the inappropriateness of aggression - suggest using the peer group to increase empathy towards the victim, raise awareness of individual responsibility and teach peers problem-solving skills that will help 'mobilise the silent majority' to act against bullying	
Salmivalli C. Participant role approach to school bullying: implications for interventions. *Journal of Adolescence* 1999; 22: 453-459.	Looks at bullying as a group phenomenon enabled and maintained by members of the class	- as per the paper above by O'Connell et al. (1999) which appears in the same journal issue, this paper also takes a wider look at the role of peers in school bullying (this is a discussion paper, not report of a study) - author describes 7 role types and the following frequencies among 573 sixth grade children: victim (11.7%), bully (8.2%), assistants of the bully (6.8%), reinforcers of the bully (19.5%), defenders of the victim (17.3%), outsiders (23.7%), and those with no clear role (12.7%) - participant roles tend to be relatively stable from one school year to another, unless some kind of intervention takes place - so transferring the victim into another class, in itself, is unlikely to change the child taking the victim role - author argues that intervention programs should make use of the different participant roles, e.g. some roles may be easier to change than the aggressive bully - suggest teaching assertiveness skills to victims and defenders is likely to be helpful; and encouraging greater empathy and involvement of outsiders	

Table F.4.1: Peer victimisation (bullying) – evaluations of interventions

Publication	Aim	Intervention details	Comments
Menesini E, Codecasa E, Benelli B, Cowie H. Enhancing children's responsibility to take action against bullying: evaluation of a befriending intervention in Italian middle schools. *Aggressive Behavior* 2003; 29: 1-14.	Evaluation of a peer-support model as an anti-bullying intervention, implemented in two Italian schools with children aged 11-14 yrs	- four aims of the intervention: (1) reduce bullying episodes by developing in bullies an awareness of their own and others' behaviour; (2) to enhance children's capacity to offer support to the victim; (3) to enhance responsibility and involvement of bystanders; (4) to improve quality of interpersonal relationships in the class - intervention based on recognition that bullying more often takes place within the context of a group of peers, and should be conceptualised as a group process - in this group process, children can play several roles: bullies, supporters and assistants of bullies, victims, defenders of victims, and outsiders - intervention based on the "befriending model" which emphasises responsibility towards others, empathic feelings, communication, emotional support - intervention implemented for one year, across the two schools 9 classes received the intervention (94 boys and 84 girls) and 5 classes were controls (63 boys and 52 girls) - intervention results showed that levels of bullying and pro-bullying behaviours (i.e. bullies, supporters and assistants) remained stable in the intervention classes, but increased in the control classes - intervention positively changed outsiders' behaviour by enhancing responsibility and empathic feelings among pupils - intervention had no effect on behaviour of victims and defenders - results showed some age differences which has implications for timing of interventions; e.g. in this study being bullied seemed to peak at 11-13 yrs and then decline	
Smith PK, Ananiadou K. The nature of school bullying and the effectiveness of school-based interventions. *Journal of Applied Psychoanalytic Studies* 2003; 5: 189-209.	Review of large-scale school-based intervention programs targeting school bullying, that have been systematically evaluated	- 9 programs included in the review from around the world - first program, the Bergen Anti-Bullying Program, took place in Norway in 1983, developed by Olweus - involved 2,500 student from 42 primary and secondary schools, 11-14 years at the time of initial evaluation - program aimed at restructuring school environment to remove positive consequences of bullying (e.g. bully being admired by peers) and increase negative consequences (e.g. punishment for undesirable behaviour); targeted strategies at individuals, class and whole school	- most of the studies focused evaluation measures on bullies and victims; growing body of literature also emphasises importance of other roles played by school peers (reinforcers, defenders, bystanders)

		- strategies included development of school policies on bullying, curriculum work, group and individual work, playground work and peer support schemes - **very positive results** showing 50% reductions in students' reports of bullying for all age and sex groups; marked reduction in other antisocial behaviour (theft, vandalism, etc) and improvement in overall 'school climate' - Bergen acted as 'model' for most other programs around the world, e.g. Rogaland (Norway); Sheffield, Wolverhampton, Liverpool and London (England), Toronto (Canada) Schleswig-Holstein (Germany), South Carolina (USA) and Flanders (Belgium) - **results from other programs mixed**; none as successful as Bergen, some showed no effect and even some adverse effects, most showed modest improvements - schools that put more effort into program implementation tended to have more positive results - more positive results with younger (primary school) children than secondary school, may be due to developmental characteristics and/or organisational features of primary vs secondary schools - other evidence has shown that bully and victim roles tend to stabilise by middle childhood (8-12 yrs), raising questions of starting intervention/prevention programs earlier i.e. in kindergarten	
NSW Department of Education and Training. *Anti-bullying Programs in NSW Schools*. www.det.nsw.edu.au/antibullying/ (last accessed 30 Jan 2004)	Website with resources and information to help schools develop anti-bullying programs and counter discrimination	- states that the following initiatives are used by many schools: – surveys to assess the amount of bullying and where it is taking place, – playground interventions, – anti-bullying committees including students, – anti-bullying lessons, – parent information and parent meetings, – procedures for staff to follow, – peer mediation programs. - Web site also summaries five effective anti-bullying programs that have been implemented in NSW schools (5 in primary, 1 in secondary), including details of some evaluation results; programs generally include school and classroom strategies	

		- Schools report reductions in bullying behaviour but few quantitative details provided - Web site also provides guidelines for schools to follow in developing and evaluating anti-bullying programs	
Rigby K. *A Meta-Evaluation of Methods and Approaches to Reducing Bullying in Pre-Schools and Early Primary School in Australia*, 2002. Canberra: Commonwealth Attorney-General's Department. www.crimeprevention.gov.au (last accessed Dec 2003)	Evaluates studies of 13 programs and strategies to prevent or reduce bullying and assesses applicability for **Australian pre-schools**	- 13 programs included in review largely the same as those included in the review by Smith and Ananiadou (2003) above, plus a couple of extras from USA (Texas and Chicago) - only 1 of 13 studies conducted in Australia - summary of findings indicates the majority of programs showed positive effects on bullying behaviour, but size of the effect generally small - some studies were not successful - reductions in bullying behaviour were found more consistently in children of primary and pre-primary ages than in older children - more commonly, reductions were found in the proportion of children being bullied and less often the proportion of bullies - also evidence that in the absence of interventions, bullying tends to increase over time; this finding emphasises the need for control groups in evaluation studies - some kinds of bullying seem more readily reduced than others, e.g. physical forms may respond more readily than verbal forms to anti-bullying programs - comparisons of the effects of intervention programs for girls vs boys have produced inconsistent results - current evidence does not indicate which components of the interventions were responsible for the reported effects; one-off studies have indicated support for curriculum content for kindergarten children that includes lessons on anger management, impulse control and encouragement of empathic feelings; one study examining use of cooperative learning approach as a teaching technique was not shown to have consistently positive effects on bullying - however, elements common to many programs include: – use of awareness raising exercises, – use of 'whole school' approach, – addressing different levels within the school, i.e. the school, the classroom, individual children, and parent/community groups, – use of school curriculum to provide lessons and activities to help develop children's knowledge, attitudes and skills,	- very useful report – Australian, recent (2002), provides good summary of main anti-bullying programs around the world; and written by Australia's bullying 'expert'

		– empowerment of children so that they can contribute to helping others involved in bully/victim problems, – specific strategies and skills to help individuals involved in bully/victim problems, and – working cooperatively with parents and parent groups - Rigby notes that current anti-bullying programs in Australia include many of these elements - Rigby notes that programs typically require teachers and parents to work together but the significance of parental involvement has not been systematically evaluated - also not clear from evidence whether the two main approaches to bullying are equally effective or more effective, i.e. the so-called 'no-blame' approach or one emphasising rules and use of negative sanctions - with regards to Australia, Rigby argues that the likelihood of successful programs will be greater where programs are implemented with younger students attending kindergartens and primary school; when teacher commitment and community involvement is high - emphasises need for future evaluative studies of bullying programs in Australia - Appendix 1 and 2 of the report include summaries of programs and initiatives currently under way in Australia; Appendix 3 has short lists of publications suitable for teachers and parents; Appendix 4 provides a good overview of each of the 13 studies, and Appendix 5 contains a table comparing key elements of the 13 studies (very good summary)	
Stevens V, De Bourdeaudjuij I, van Ooost P. Anti-bullying interventions at school: aspects of programme adaptation and critical issues for further programme development. *Health Promotion International* 2001; 16: 155-167.	Examines the use of the Bergen anti-bullying program as a template for other programs and assesses their fidelity to the original model	- states that the primary aims of the Bergen program are to increase adults' and students' awareness of problems of peer aggression and victimisation, and to encourage active involvement of adults and peers in resolving bullying/victim incidents - based on articulation of clear rules against bullying behaviour; stresses reciprocal relationship between bullies or victims and their social environment - authors use 'set of characteristics of model programs' to assess strengths and limitations of Bergen model - confirm a significant number of strengths consistent with a 'good' model program; identify three key weaknesses: no clear link between program objectives and program methods, no clear description of the skills required to conduct the program,	

		and component of parental involvement has proven less feasible to implement than others - authors then compare the Bergen program with three anti-bullying programs based on it (conducted in England, Canada and Belgium) - comparison found only minor differences between the programs, primarily explained by cultural differences in the organisation of school services and involvement of the local community - noted that the three other programs did not report as successful results as the Bergen program, but the current programs comparison indicates the different results cannot be attributed to 'poor program adaptation'	
Centre for Adolescent Health, University of Melbourne. *Gatehouse Project*. http://www.rch.unimelb.edu.au/gatehouseproject/ (last accessed 23 Jan 2004)	School-based intervention including individual and environmental components, aimed at improving students' emotional well-being	- intervention implemented between 1997-1999, RCT trial involving 26 secondary schools in metropolitan and regional Victoria; 12 schools received intervention, 14 controls - outcomes that were targeted included reported depressive symptoms, other common emotional problems, and use of alcohol, cigarettes and marijuana - intervention designed to make changes in the social and learning environments of the school as well as promoting change at the individual level; strategies targeted at individual, classroom, whole school, and school-community interactions - three specific groups of strategies: increasing physical and personal security; improving communication skills, and enhancing and developing positive regard for others - researchers worked with participating schools to select specific strategies that were appropriate to each context - follow-up results showed reductions in reported cigarette smoking, drinking and cannabis use but no reduction in depressive symptoms or other common emotional problems - further follow-up is under way	- not specific to bullying, but is a school-based intervention focused on students' behavioural and emotional well-being