

# Toward Flourishing for All...

Mental Health Promotion and Mental Illness Prevention  
Policy Background Paper

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**“That country is the richest which nourishes the greatest number  
of noble and happy human beings.”**

**John Ruskin 1819–1900**



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## EXECUTIVE SUMMARY

By 2030, mental illness will be the leading cause of disability in high-income countries (Mathers & Loncar, 2006). Treatment of mental disorders and illnesses is crucial but will not stem the tide. Changing the trend toward higher rates of mental illness among Canadians requires a shift in thinking about “mental health” – one that moves away from preoccupation with illness and toward discovery of the potential found in promoting good mental health and preventing illness. Positive mental health is something that affects all Canadians each and every day. It is a basic human right and a resource for quality of life that enables individuals, families, organizations and communities to navigate challenges and realize their aspirations (Jané-Llopis & Braddick, 2008). It is the enabler of social participation and productivity that lead to a healthy and economically sustainable society (Moodie & Jenkins, 2005).

Promoting mental health and preventing mental illness involve actions that strengthen the resilience of individuals and families, create stronger and healthier communities and address the social and structural determinants of mental health, such as poverty, access to education, good housing and other resources for health (European Commission, 2008a). Because many of these determinants lie beyond the reach of the health sector, effective mental health promotion (MHP) and mental illness prevention (MIP) depend on collaboration with other sectors, such as employment, education, housing, social services, the justice system, culture, arts, sport, recreation and others.

Momentum for MHP & MIP is growing around the globe. Several organizations and nations are leading the way, including the World Health Organization, Australia, New Zealand, the European Union, England, Ireland, Scotland and others.

Canada enjoys a legacy of leadership in health promotion, including the development of seminal documents such as *Achieving Health for All: A Framework for Health Promotion* and *Mental Health for Canadians: Striking a Balance*. But despite numerous and some well recognized initiatives across the provinces and territories, it remains one of the few westernized nations without a national mental health policy. Now, however, Canada is in the enviable position of being able to learn from other jurisdictions that have developed and implemented national mental health policies and plans. Examination of the successes and challenges of developing, designing, determining the content/focus of, implementing, monitoring and evaluating these MHP & MIP policies and plans can provide insights to inform policy actions in Canada. Thus, the purpose of this document is to examine the experiences of other jurisdictions in order to inform deliberations about what national- and provincial-level MHP & MIP policies and plans might look like in the Canadian context. These deliberations will begin in November 2008 at a National Mental Health Promotion and Mental Illness Prevention Think Tank in Calgary, Alberta.

For this purpose, national-level mental health, MHP & MIP policies in Australia, New Zealand, the European Union, England, Ireland and Scotland were reviewed according to five key aspects of developing and implementing MHP policy: collaborative action in developing and implementing the policy, policy design, policy content, policy implementation, and monitoring and evaluation.

The review of other jurisdictions revealed that national-level mental health, MHP & MIP policies have generated actions and results on the ground, including an impressive range and number of national, state/territorial and local initiatives; successful anti-stigma and anti-discrimination programs; increased mental health literacy of the public; and increased community interest and involvement in mental health. For successful policy initiatives, countries received international recognition, government understanding of and commitment to mental health increased, and capacity for MHP & MIP was enhanced through commitment of resources and opportunities for training. Factors that contributed to success included strong leadership, government commitment, allocation of resources, multi-sector collaboration, a focus on evidence-based practice, and specific training in MHP & MIP.



All jurisdictions reviewed encountered challenges putting policy into action. Facilitating meaningful participation of other sectors was consistently reported as a challenge. Other challenges included establishing a common language and vision of positive mental health; the need for leadership from government and coalitions to champion positive mental health, communicate the vision and coordinate cross-government and cross-sector collaboration; integration of MHP & MIP policies and plans within public health and within existing programs and organizations; insufficient resources; regression to policy focused on treatment and service delivery; and variable execution of policy and action plans despite clear and appropriate policy direction.

## **RECOMMENDATIONS AND QUESTIONS FOR FURTHER CONSIDERATION**

The successes and challenges experienced by other jurisdictions raise some key questions for consideration in the Canadian context. These are listed here along with some recommendations for action.

### **Question 1: How can we work collaboratively across different levels and sectors and segments of society to promote mental health and prevent mental illness?**

#### *Recommendations*

1. MHP & MIP policy development and implementation processes should be congruent with the principles and practices of MHP. This means that a wide spectrum of stakeholders, including the general public, should be engaged in MHP & MIP policy development and implementation in Canada. This will require visionary leadership and mastery of the “art of connecting.”
2. A shared understanding of positive mental health across the various sectors of society is a crucial platform for successful collaborative action. Achieving a shared understanding will require ongoing efforts to engage the diverse array of stakeholders in ways that are culturally appropriate and meaningful.

#### *Questions for further deliberation*

1. Who, specifically, needs to be engaged in the processes of developing and implementing MHP & MIP policies and plans?
2. What is the most effective way to engage these individuals, groups, communities, organizations and sectors?
3. Who will lead these processes of engagement?

### **Question 2: Which policy model is best for effective MHP & MIP in Canada?**

#### *Recommendation*

Further exploration of the merits of various policy models for MHP & MIP policy in Canada should be conducted. Emphasis should be placed on a model that:

- enables enactment of the fundamental principles and processes of MHP & MIP – i.e., a positive conceptualization of mental health; participatory, empowerment-oriented approaches; approaches that build on strengths and assets; and collaborative, multi-sectoral action on the structural determinants of mental health;
- enables integration of MHP & MIP into mental illness treatment and services; and
- ensures a sustained emphasis on MHP & MIP actions.



*Questions for further deliberation*

1. How can MHP & MIP policy be designed such that it:
  - enables enactment of the fundamental principles of MHP & MIP?
  - enables integration of MHP & MIP into mental illness treatment and services?
  - ensures a sustained emphasis on MHP & MIP actions?
2. How might cross-sectoral action for MHP & MIP be facilitated through policy design?

**Question 3: What are the key elements to be included in an MHP & MIP Policy for Canada?**

*Recommendations*

1. A shared vision for positive mental health, MHP & MIP in Canada is needed to build momentum and generate energy for action.
2. MHP & MIP policy content should be informed by a review and analysis of existing policies and programs in mental health, health and other sectors.
3. The selection of two or three priority areas would help to focus initial efforts.

*Questions for further deliberation*

1. Who will lead policy development and determination of policy content?
2. How will policy content and focus be determined?

**Question 4: How can we support effective implementation at different levels and establish the infrastructure and resources needed?**

*Recommendation*

Implementation infrastructure will depend on MHP & MIP policy design, but a specific infrastructure specifically for MHP & MIP (or perhaps health promotion in general as well) is highly desirable. Strong leadership is required to champion MHP & MIP and to keep efforts focused on promotion and prevention.

*Questions for further deliberation*

1. Who will lead implementation of MHP & MIP policy in Canada? How can we most effectively ensure sustained leadership and oversight of MHP & MIP policy implementation?
2. What existing bodies, policies and programs can support MHP & MIP action in Canada? Are new institutions needed to oversee MHP & MIP policy implementation and evaluation? Or is it possible to integrate MHP & MIP policies and plans into existing structures at the national, provincial/territorial and local levels?
3. What resources are required (financial, human, training, research, evaluation)? Are new funding mechanisms needed to secure these resources?
4. How can we facilitate and invest in research to guide MHP & MIP policy and practice?
5. How do we expand the knowledge base for positive mental health in order to effectively translate knowledge into practice?



6. How can we build capacity and train the workforce in public health and other sectors to prepare them to become enablers and advocates for MHP & MIP across sectors?
7. How can we sustain the engagement of key stakeholders in an ongoing and mutually generative and beneficial manner?

**Question 5: How do we evaluate MHP & MIP policy impact to ensure accountability for mental health?**

*Recommendation*

Canada should develop a set of positive mental health indicators to mark progress in MHP & MIP efforts. The existing capacity of Statistics Canada makes this organization a logical candidate for conducting this work. The indicator sets developed internationally by Scotland and by C. L. Keyes (2007) could be used to inform indicator development in Canada.

*Questions for further deliberation*

1. What data does Canada already collect regarding positive mental health?
2. What are the facilitators of and barriers to the creation of a national-level data set for positive mental health? How can these be addressed to facilitate development of a robust data set?



D'ici 2030, la maladie mentale constituera la principale cause d'invalidité dans les pays à revenu élevé (Mathers et Loncar, 2006). Il est essentiel de traiter les maladies mentales, mais cela ne renversera pas la tendance. Pour empêcher que les taux de maladie mentale continuent d'augmenter chez les Canadiens, il faut modifier la façon dont on considère la « santé mentale » et passer d'une perception où on s'inquiète de la maladie à une perception axée sur la découverte du potentiel associé à la promotion de la santé mentale et à la prévention de la maladie. Une bonne santé mentale est un aspect qui touche *tous* les Canadiens, tous les jours. Il s'agit d'un droit de la personne fondamental et d'une ressource pour atteindre une qualité de vie qui permet aux gens, aux familles, aux organisations et aux communautés de faire face aux défis et de réaliser leurs aspirations (Jané-Llopis et Braddick, 2008). C'est le facteur qui permet la participation sociale et le rendement, lesquels mènent à une société saine et durable sur le plan économique (Moodie et Jenkins, 2005).

Pour promouvoir la santé mentale et prévenir la maladie mentale, il faut des mesures pour renforcer la résistance des gens et des familles, créer des communautés plus saines et plus fortes et s'attaquer aux déterminants sociaux et structurels de la santé mentale, comme la pauvreté, l'accès aux études, un bon logement et d'autres ressources pour la santé (Commission européenne, 2008a). Étant donné que bon nombre de ces déterminants ne relèvent pas du secteur de la santé, l'efficacité de la promotion de la santé mentale (PSM) et de la prévention de la maladie mentale (PMM) dépend de la collaboration avec d'autres secteurs, comme l'emploi, l'éducation, le logement, les services sociaux, le système juridique, la culture, les arts, les sports, les loisirs et ainsi de suite.

Les efforts en matière de PSM et de PMM prennent de l'ampleur partout dans le monde. Plusieurs organisations et pays ouvrent la voie, notamment l'Organisation mondiale de la Santé, l'Union européenne, l'Australie, la Nouvelle-Zélande, l'Angleterre, l'Irlande, l'Écosse et d'autres.

Le Canada a un passé de chef de file en matière de promotion de la santé et a notamment élaboré des documents fondamentaux comme *La santé pour tous: Plan d'ensemble pour la promotion de la santé* et *La santé mentale des Canadiens : vers un juste équilibre*. Toutefois, malgré des initiatives nombreuses et parfois éprouvées au sein des provinces et des territoires, le Canada reste l'un des rares pays occidentaux à ne pas avoir de politique nationale de santé mentale. Cependant, à l'heure actuelle, il occupe une position enviable, en ce sens qu'il peut tirer des leçons des autres pays qui ont élaboré et mis en œuvre des politiques et des plans nationaux en matière de santé mentale. Le fait d'examiner les réussites et les difficultés associées au contenu et à l'orientation de ces politiques de PSM et de PMM ainsi qu'à leur élaboration, à leur conception, à leur mise en œuvre et à leur évaluation peut permettre de recueillir des données qui éclaireront les initiatives du Canada. Le présent document vise donc à examiner les expériences d'autres pays afin d'éclairer les discussions sur la forme que pourraient prendre les plans et les politiques nationales et provinciales de PSM et de PMM dans le contexte canadien. Ces discussions débiteront en novembre 2008, dans le cadre d'un exercice de réflexion national sur la PSM qui aura lieu à Calgary, en Alberta.

À cette fin, nous avons examiné les politiques nationales en matière de santé mentale, de PSM et de PMM de l'Australie, de la Nouvelle-Zélande, de l'Union européenne, de l'Angleterre, de l'Irlande et de l'Écosse en fonction des cinq principaux aspects liés à l'élaboration et à la mise en œuvre d'une politique de PSM : la collaboration; la conception; le contenu; la mise en œuvre; la surveillance et l'évaluation.

Selon cet examen, les politiques nationales en matière de santé mentale, de PSM et de PMM ont généré des mesures et des résultats sur le terrain, notamment une quantité et une variété impressionnantes d'initiatives locales, régionales, territoriales et nationales, des programmes anti-discrimination et anti-préjugés efficaces, un accroissement des connaissances du public sur la santé mentale ainsi qu'une augmentation de l'intérêt et de la participation des communautés dans le domaine de la santé mentale. Lorsque les initiatives stratégiques sont efficaces, les pays font l'objet d'une reconnaissance internationale. Les gouvernements comprennent mieux la santé mentale et ont accru leur engagement à cet égard. De plus, les capacités de PSM et de PMM ont été renforcées grâce aux ressources qui y ont été consacrées et par des possibilités de formation. Parmi les facteurs de réussite, mentionnons un leadership fort, l'engagement du gouvernement, l'allocation de ressources, une collaboration multisectorielle, l'attribution d'une place importante à la pratique fondée sur des faits et une formation adaptée sur PMM et la PSM.



Tous les pays examinés ont fait face à des difficultés au moment de mettre en œuvre leurs politiques. Dans tous les cas, on a signalé qu'il avait été difficile de faciliter une participation importante des autres secteurs. Parmi les autres difficultés, mentionnons : l'établissement d'un langage commun et d'une vision commune d'une bonne santé mentale; la nécessité pour le gouvernement et les coalitions de jouer un rôle de chef de file afin d'être les champions d'une bonne santé mentale, de communiquer la vision et de coordonner la collaboration intergouvernementale et intersectorielle; l'intégration des plans et des politiques de PMM et de PSM dans la santé publique et dans les programmes et les organismes existants; des ressources insuffisantes; un recul vers des politiques axées sur les traitements et l'offre de services; une mise en œuvre variable des plans d'action et des politiques malgré des directives claires et pertinentes.

## RECOMMANDATIONS ET QUESTIONS À ÉTUDIER

Les réussites et les difficultés des autres pays soulèvent des questions importantes à étudier dans le contexte canadien. Voici ces questions ainsi que les recommandations qui s'y rattachent.

### **Question 1: Comment les différents niveaux, secteurs et segments de la société peuvent-ils travailler en collaboration pour promouvoir la santé mentale et prévenir la maladie mentale?**

#### *Recommandations*

1. Les processus d'élaboration et de mise en œuvre des politiques de PSM et de PMM devraient être conformes aux principes et aux pratiques associés à la PSM. Ainsi, une vaste gamme d'intervenants, y compris le grand public, devraient participer à l'élaboration et à la mise en œuvre de ces politiques au pays. À cette fin, il faut avoir un leadership visionnaire et maîtriser l'« art de communiquer ».
2. Il est essentiel que le concept de bonne santé mentale soit compris de la même façon par les différents secteurs de la santé pour pouvoir prendre des mesures concertées efficaces. Pour parvenir à cette compréhension commune, il faudra faire des efforts constants afin de faire participer les divers intervenants d'une façon constructive et adaptée à leur culture.

#### *Questions à étudier plus avant*

1. Qui sont précisément les intervenants qui doivent participer à l'élaboration et à la mise en œuvre des politiques et des plans de PSM et de PMM?
2. Quel est le moyen le plus efficace de faire participer les gens, les groupes, les communautés, les organisations et les secteurs?
3. Qui dirigera ces processus de participation?



## **Question 2: Quel est le meilleur modèle stratégique pour assurer l'efficacité de la PSM et de la PMM au Canada?**

### *Recommandation*

Il faudrait étudier de façon plus approfondie les avantages des divers modèles stratégiques pour les politiques de PSM et de PMM au Canada. Il faudrait mettre l'accent sur un modèle permettant ce qui suit :

- faire approuver les principes et les processus fondamentaux associés à la PSM et la PMM, c'est-à-dire une conceptualisation favorable de la santé mentale, des méthodes participatives axées sur l'autonomisation, des stratégies qui tirent parti des points forts et des atouts et des interventions concertées et intersectorielles en ce qui concerne les déterminants structurels de la santé mentale;
- intégrer la PSM et la PMM dans le traitement de la maladie mentale et les services;
- veiller à toujours accorder une grande place aux mesures de PSM et de PMM.

### *Questions à étudier plus avant*

1. Comment peut-on concevoir une politique de PSM et de PMM qui permet : \_de faire approuver les principes et les processus fondamentaux associés à la PSM et la PMM? \_d'intégrer la PSM et la PMM dans le traitement de la maladie mentale et les services? \_de veiller à toujours accorder une grande place aux mesures de PSM et de PMM?
2. Comment la façon dont est conçue la politique peut-elle faciliter les mesures intersectorielles touchant à la PSM et à la PMM?

## **Question 3: Quels sont les principaux éléments qu'il faut inclure dans une politique canadienne de PSM et de PMM?**

### *Recommandations*

1. Il faut avoir une vision commune de ce que sont une bonne santé mentale, la PSM et la PMM afin de progresser et de donner l'énergie nécessaire pour intervenir.
2. Le contenu d'une politique de PSM et de PMM devrait reposer sur un examen et une analyse des politiques et des programmes existants dans les domaines de la santé mentale et de la santé et dans d'autres secteurs.
3. Le fait de choisir deux ou trois secteurs prioritaires aiderait à orienter les premiers efforts.

### *Questions à étudier plus avant*

1. Qui dirigera l'élaboration de la politique et le processus de détermination de son contenu?
2. Comment déterminera-t-on le contenu et l'orientation de la politique?

## **Question 4: Comment pouvons-nous faciliter une mise en œuvre efficace aux différents échelons et établir l'infrastructure et les ressources nécessaires?**

### *Recommandation*

L'infrastructure de mise en œuvre dépendra de la conception de la politique, mais une infrastructure propre à la PSM et la PMM (ou peut-être aussi propre à la promotion de la santé en général) serait hautement souhaitable. Il



faut un leadership solide pour défendre la PSM et la PMM et faire en sorte que les efforts restent axés sur la promotion et la prévention.

*Questions à étudier plus avant*

1. Qui devrait diriger la mise en œuvre de la politique de PSM et de PMM au Canada? Quel est le moyen le plus efficace d'assurer une supervision et un leadership constants dans le cadre de la mise en œuvre de la politique?
2. Quels sont les organismes, les politiques et les programmes existants qui peuvent faciliter les mesures de PSM et de PMM au Canada? Faut-il de nouvelles institutions pour superviser la mise en œuvre et l'évaluation de la politique ou est-il possible d'intégrer les politiques et les plans de PSM et de PMM aux structures existantes à l'échelle nationale, provinciale, territoriale et locale?
3. Quelles sont les ressources requises (ressources financières et humaines, formation, recherche, évaluation)? Faut-il de nouveaux mécanismes de financement pour les obtenir?
4. Comment pouvons-nous faciliter et financer des travaux de recherche pour orienter les politiques et les pratiques de PSM et de PMM?
5. Comment pouvons-nous élargir la base de connaissances sur une bonne santé mentale de façon à pouvoir effectivement transformer les connaissances en pratiques?
6. Comment pouvons-nous renforcer les capacités des employés du domaine de la santé publique et d'autres secteurs et les former afin de les préparer à devenir des catalyseurs et des défenseurs de la PSM et de la PMM entre les secteurs?
7. Comment pouvons-nous maintenir la participation des principaux intervenants de façon constante et mutuellement avantageuse et générative?

**Question 5: Comment allons-nous évaluer les effets de la politique de PSM et de PMM pour pouvoir rendre compte des progrès en matière de santé mentale?**

*Recommandation*

Le Canada devrait établir un ensemble d'indicateurs d'une bonne santé mentale pour évaluer les progrès faits dans les efforts de PSM et de PMM. La capacité existante de Statistique Canada en fait le candidat logique pour effectuer ce travail. Le Canada pourrait se servir des ensembles d'indicateurs établis par l'Écosse et par Keyes (2007).

*Questions à étudier plus avant*

1. Quelles sont les données qui sont déjà recueillies au Canada sur la bonne santé mentale?
2. Quels sont les éléments qui favorisent la création d'un ensemble de données national pour une bonne santé mentale et ceux qui y font obstacle? Que peut-on faire à cet égard pour faciliter l'établissement d'un ensemble de données solide?



## BACKGROUND

In February 2003, Canada's first-ever national study of mental health, mental illness and addiction was conducted by the Standing Senate Committee on Social Affairs, Science and Technology. This study generated the report *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Kirby & Keon, 2006). A key recommendation was the establishment of a Mental Health Commission of Canada, which has now come to fruition. The Commission has established four key initiatives<sup>1</sup>:

- Reducing stigma and discrimination
- Developing a knowledge exchange centre
- Creating a national strategy
- Homeless research demonstration projects

It is the third initiative – creating a national strategy – with which this paper is concerned, although it may inform the other initiatives. This paper is also intended to help inform mental health promotion and mental illness prevention (MHP & MIP) policy development and implementation at the provincial and territorial level.

The seeds for this document, and the Mental Health Promotion Think Tank that it will inform, were first sown at a Mental Health Promotion Summer Institute held in 2005 in Toronto. Co-chaired by the Centre for Addiction and Mental Health and the Centre for Health Promotion at the University of Toronto, the Institute generated interest in ongoing conversations about the development of MHP policy in Canada.

Two years later, BC Mental Health and Addiction Services hosted a Mental Health Promotion Symposium, No Health Without Mental Health: Community Approaches to Mental Health Promotion, in conjunction with the 2007 International Union of Health Promotion and Education conference in Vancouver. Partners included: Public Health Agency of Canada; Centre for Addiction and Mental Health; Alberta Mental Health Board; BC Ministry of Health; Canadian Mental Health Association; Centre for Health Promotion, University of Toronto; and the Government of Ontario. Many people participated in the symposium and indicated not only their interest in mental health promotion, but also a desire to stay connected, learn more, and ideally, influence mental health promotion in Canada.

Following the symposium, conversations continued among a group of enthusiastic mental health promotion experts from across Canada. This group evolved into a pan-Canadian steering committee<sup>2</sup> to plan a national think tank that would engage key decision makers, experienced practitioners, and academics in dialogue about mental health promotion and mental illness prevention policy development in Canada. The intent of the Think Tank was to generate recommendations for submission to the Mental Health Commission of Canada for consideration in its national mental health framework; and to help inform mental health promotion and mental illness prevention policy development and implementation at the provincial and territorial level. An inquiry to the Commission regarding this was received favourably, and planning began for a National Mental Health Promotion and Mental Illness Prevention Think Tank, held in Alberta in November 2008.

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<sup>1</sup> In addition, the Commission has created eight advisory committees (Child and Youth; Mental Health and the Law; Seniors; First Nations, Inuit and Metis; Workforce; Family Caregivers; Service Systems; and Science) to support the Commission in engaging a broad array of stakeholders.

<sup>2</sup> The Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention



Two research consultants, Kathy GermAnn and Paola Ardiles, were commissioned to prepare this paper, which has the following objectives:

- To provide a review and analysis of international MHP & MIP strategies and policies, including evidence of their effectiveness; and,
- To explore how other jurisdictions have used MHP strategies to address or reduce the impact of societal trends and environmental changes associated with increased risk of mental distress.



## APPROACH AND METHODOLOGY

To guide the review of mental health promotion and mental illness prevention policies in other jurisdictions, an analytical framework was developed. The framework included working definitions of key terms and a series of guiding questions regarding the development and implementation of national-level MHP & MIP policies and strategies.

The review focused specifically on:

- Developing a broad overview of MHP & MIP policy in each selected jurisdiction, including an analysis of the context for policy development and implementation, an overview of the key features of the policy/strategy and a description of the historical evolution of mental health, MHP & MIP policy/strategy in the jurisdiction.
- Conducting analyses of the factors and dynamics that enable and impede successful MHP & MIP policy development and implementation at the national level – establishing what works and does not work in promoting mental health and preventing mental illness.

The framework guided a review of documentation from international jurisdictions with well-established national level MHP & MIP policies/strategies. Jurisdictions reviewed included Australia, England, the European Union, Ireland, New Zealand and Scotland. Information was also collected regarding specific aspects of MHP- & MIP-related policy/action in Chile, Sweden and the United States.

A review of selected academic and grey<sup>3</sup> literature was conducted, as was a review of websites relevant to national-level MHP & MIP policy, particularly in the jurisdictions listed above. This generated over 100 documents, which were subsequently reviewed and analyzed. A limitation of the results reported herein is that time and resource constraints precluded in-depth analyses of the academic literature. In addition, not all documents published by jurisdictions were available on the Internet.

To further inform the review, interviews with 10 international MHP & MIP experts were conducted. Criteria for selecting interviewees included expertise in MHP & MIP; intimate knowledge of the jurisdiction's MHP & MIP policy/strategy, especially regarding development and implementation of the policy; willingness to participate; and a balance of interviewees with academic and policy experience. See Appendix C for the interview guide that was developed for this purpose.

These key informants generously provided rich, current and “behind-the-scenes” insights into the dynamics that enable and constrain effective MHP & MIP policy development and implementation.

## ORGANIZATION OF THE PAPER

The paper begins with an introduction, followed by a “primer” in mental health, MHP & MIP. In the next section, a high-level overview of MHP & MIP policy and plans in selected international jurisdictions is provided. The paper concludes with an analysis of successes and challenges experienced by other jurisdictions in developing and implementing MHP & MIP policies and plans – and of how these experiences translate to the Canadian context. Some recommendations are made, and questions for further deliberation are posed. While the body of the document will serve as a baseline to inform dialogue, these questions are intended to stimulate discussion and debate and thus generate new ideas, new lines of sight and new paths for effective action. It is expected that these new insights will guide development of recommendations to the Mental Health Commission of Canada. It is also

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<sup>3</sup> Grey literature is that which is not published commercially nor indexed by major database vendors; it is typically not peer-reviewed (University of British Columbia, 2008).



hoped that the ideas generated at the Mental Health Promotion Think Tank will catalyze new policies and actions throughout the provinces and territories.

A detailed review of jurisdictions is provided in a companion document: *Toward Flourishing for All Companion Document: Mental Health Promotion and Mental Illness Prevention Policy in International Jurisdictions*.



## INTRODUCTION

In 1986, Jake Epp, then Canada’s Minister of National Health and Welfare, released the discussion document *Achieving Health for All: A Framework for Health Promotion*. In this document, Epp articulated a new vision of health, noting that health is far more than the mere absence of illness; rather, he said it is an “essential dimension of the quality of our lives” – the ability to make choices and gain satisfaction from living (Health and Welfare Canada, 1986: 2). This vision of health clearly accentuated the importance of mental and social well-being.

In *Achieving Health for All*, Epp noted that while Canada had developed a strong health care system, new approaches were required to resolve three perplexing issues that were undermining the health of many Canadians: health inequities between high and low income groups, increasing rates of preventable diseases, and the challenges of coping with chronic conditions and mental health problems. Health promotion was introduced in this document as an approach that would address these challenges and thereby complement and strengthen the health system. As the report suggested, it was conceived as the means to “achieve health” for all Canadians.

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Health promotion was conceived as the means to “Achieving Health for All.”

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Two years later, Epp released a second discussion document, *Mental Health for Canadians: Striking a Balance*, noting that issues related to mental health and mental disorder were crucially important in actions to improve the quality of life of Canadians.

Despite the compelling call for action in *Striking a Balance*, progress has been slower than hoped, and the situation regarding mental illness is becoming more urgent. By 2030 it is predicted that depression will be the leading cause of disability in high income countries, followed by heart disease, dementias and alcohol use disorders (Mathers & Loncar, 2006). The social and economic toll extracted by mental illness will be significant. Effective treatment services are essential for those experiencing mental illness, but offering treatment alone will not stem the tide.

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Sixty percent of people with mental health problems don’t seek care from health professionals – and if they did, it would be impossible to fill the need (Stephens & Joubert, 2001). New approaches are needed, particularly those that promote mental health and prevent mental illness from developing in the first place. As Keyes and Lopez (2002: 46) have noted, “[T]he science of mental illness has produced effective treatments for more ‘broken-down’ people; it remains ineffective for preventing more people from ‘breaking down.’” Mental health problems cannot be

brought under control by treating individuals one at a time (Nelson et al., 1996: 161).

Stemming the tide of mental illness requires a shift in thinking about “mental health,” which is often erroneously interpreted in terms of mental illness. Positive mental health affects *all* Canadians each and every day. There are debates about how “mental health” is most accurately defined, but what seems most important is reaching a shared understanding about its essence and importance. Positive mental health is a basic human right and a resource for quality of life that enables individuals, families, organizations and communities to navigate challenges and realize their aspirations (Jané-Llopis & Braddick, 2008). It is the enabler of social participation and productivity, which lead to a healthy and economically sustainable society (Moodie & Jenkins, 2005). Hence, from a human rights perspective, nations should be held accountable for ensuring the mental (and physical) health of their populations.



Mental health promotion (MHP) is concerned with helping people take control over their lives and improve their mental health. Many approaches are possible, but the focus is on creating environments conducive to good mental health and well-being for individuals, communities and populations. Creating supportive environments requires action on the many social and economic determinants of mental health, including healthy child development, employment and working conditions, social support networks, income and social status, and education. A key focus is addressing health inequities such as poverty and social inclusion that significantly impact mental health. Similarly, mental illness prevention (MIP), which aims to reduce the risk and incidence of illness by enhancing protective factors and minimizing risk factors, requires actions well beyond the purview of the health sector. The promotion of mental health and the prevention of mental illness thus require collaborative action with individuals, groups and sectors whose mandates and activities are integrally linked to health and well-being. In other words, mental health is everybody's business (WHO, 2005a).

Despite numerous and some well-recognized initiatives across the provinces and territories, Canada is one of the few western nations without a national-level mental health policy. It is now, however, in the enviable position of being able to learn from other jurisdictions – Australia, New Zealand, the European Union, England, Ireland and Scotland – that have developed and implemented national mental health policies and plans. Specifically, examination of the successes and challenges of developing, designing, selecting the content/focus of, implementing, monitoring and evaluating these MHP & MIP policies and plans can provide insights to inform policy actions in Canada. This is the focus of the pages herein, based on the assumption that an understanding of the “lessons learned” in these other jurisdictions will ground deliberations at the Mental Health Promotion Think Tank about what national- and provincial-level mental health promotion and mental illness prevention policies should look like in the Canadian context.

Mental health policy provides significant leverage for action on the ground (WHO, 2005a). It is hoped that establishment of high-level MHP & MIP policies in Canada will significantly advance the nurturance of a mentally healthy Canadian society – one in which all people have the opportunity to experience optimal mental health.

Keyes (2002: 210) describes optimal mental health as “flourishing.” To flourish is to “be filled with positive emotion and to be functioning well psychologically and socially”. Given the right conditions and dynamics, individuals, groups, communities and societies can flourish. Recent developments – particularly establishment of the Mental Health Commission of Canada and its stated priority of developing a national mental health policy – inspire hope for strengthened mental health promotion and mental illness prevention actions in Canada. The time has come to build upon the legacy and spirit of *Achieving Health for All* and *Striking a Balance*, and move the agenda forward with a vision of a flourishing, mentally healthy Canadian population – Flourishing for All.

There are at least 16 compelling reasons why this is a valuable, if not crucial, endeavour for Canada. These reasons are offered in the next section.

## **16 REASONS TO INVEST IN MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION**

1. Positive mental health is a basic human right. It is “fundamental to all human and social progress and is a prerequisite to a happy and fulfilled life for individual citizens, for effectively functioning families and for social cohesion” (Jané-Llopis & Braddick, 2008: 3). It is the foundation of a healthy society and a healthy economy (Moodie & Jenkins, 2005).



2. The growing incidence and prevalence of mental illness threatens human and social progress. By 2020, mental illness will be the leading cause of disability in the Western world and mental health problems will account for 15 percent of the global burden of disease (WHO, 2001; Murray & Lopez, 1996).
3. The number of Canadians in distress could be on the rise given 2001 trends in child poverty, income disparities, involuntary part time work, single parenting, youth unemployment and declining expenditures on health, welfare and education. The situation regarding youth is of particular concern. In 1978, youth exhibited the lowest level of distress within the Canadian population. By 1998, however, they exhibited the highest level of distress (Stephens & Joubert, 2001).
4. The significant and growing global and national burden of mental illness cannot be stemmed by treating one individual at a time. A proactive population-based approach that promotes positive mental health and stops people from becoming mentally ill is required.
5. MHP & MIP can reduce the enormous, wide-ranging and long-lasting economic impact of mental disorders (WHO, 2004), including, in Canada, the \$14.4-billion annual price tag in terms of treatment and disability costs (Stephens & Joubert, 2001).
6. Statistically, one in every four people will experience a mental health problem or illness at some point in their lives (WHO, 2001), taking an enormous human toll that cannot be measured exclusively in economic terms. The human burden of mental illness includes psychic pain, feelings of guilt, helplessness, hopelessness, and exacerbated anxiety and depression both for the persons suffering the illness and for the people who love and care for them (Lehtinen et al., 1996). Financial difficulties, discrimination and marginalization impose additional burdens on these people.
7. Poor mental health disproportionately affects those who are socially and economically disadvantaged while also contributing directly to poverty (Jané-Llopis & Braddick, 2008; Moodie & Jenkins, 2005).
8. People are put at risk for and develop mental illness because an array of individual, family, community and social factors erode their mental well-being (Keyes, personal communication, June 2008). Addressing these factors is key to preserving and enhancing positive mental health.
9. MHP & MIP, and their focus on the structural determinants of mental health, can foster safer and healthier families, workplaces and communities; higher educational achievement; improved interpersonal relationships; and personal dignity (WHO, 2005a; Moodie & Jenkins, 2005).
10. Research has demonstrated that anything less than flourishing is associated with increased impairment and burden to self and society (Keyes, 2007a: 95). People who are flourishing have been found to miss fewer days at work, have fewer chronic physical diseases, have the lowest rates of healthcare utilization and have the highest levels of psychosocial functioning (Keyes, 2007). In contrast, the absence of positive mental health is correlated with the presence of mental illness and physical disease (Keyes, 2007a).
11. Not only does MHP promote positive health, but it also helps reduce risk behaviours (e.g., tobacco, alcohol and drug misuse; unsafe sex); social and economic problems (e.g., school dropout rates, crime, absenteeism from work, intimate partner violence); and the rates and severity of, and mortality from, physical and mental illness (Moodie and Jenkins, 2005: 37).
12. Positive mental health contributes fundamentally to the extent to which people feel able and motivated to exercise choice and control and to adopt a healthy lifestyle (National Institute for Mental Health in England, 2005: 1).
13. Mental illness and poor mental health significantly affect creativity and productivity in the workplace. An estimated 30–40 percent of sick days are attributable to mental illness (Moodie & Jenkins, 2005). Finding



ways to enhance productivity and creativity in the workplace is increasingly important as the baby boomer generation begins to retire and the supply of workers is reduced.

14. Positive mental health is essential for school success (Jané-Llopis & Braddick, 2008; Keyes, personal communication, June 2008). School studies show the importance of mental health for learning – anxious and depressed children perform less well academically (Moodie & Jenkins, 2005). Mental health problems lead to early school-leaving (Jané-Llopis & Braddick, 2008).
15. A key to treatment of mental illness is reorienting the individual to the signs and symptoms of flourishing – this is critical for recovery (Keyes, personal communication, June 2008). This means that mental health promotion is essential even for those experiencing mental illness.
16. Positive mental health is an essential ingredient in quality of life from birth to death.



## A PRIMER IN MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION

In this section, an overview of basic principles and processes of mental health promotion and mental illness prevention is presented.

### MENTAL HEALTH

In the Canadian document, *Striking a Balance*, Epp (1988: 4) defined mental health as:

“The capacity of the individual, the group, and the environment to interact in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective, and relational<sup>4</sup>), the achievement of individual and collective goals consistent with justice; and, the attainment and preservation of conditions of fundamental equality.”

Mental health, from this perspective, is a resource generated from the interaction of the energy, strengths, and abilities of the individual in effective transaction with other people and with opportunities and influences in the environment (Epp, 1988: 4). Thus individuals, other people, and the environment interact dynamically to produce mental health – each shapes and is shaped by interactions with the other. Mental health is improved when the social and legal environments uphold human rights, when groups act to support an individual or create environmental conditions that foster health and when individuals acquire skills that enable them to meet personal needs, contribute to the life of the community, and improve the environment (Epp, 1988: 4).

Epp (1988: 5) further noted that human interactions are grounded in societal values and therefore that any definition of mental health must reflect “the kind of people we think we should be, the goals we consider desirable, and the type of society we aspire to live in.” Thus, values relating to human equality, freedom of choice, social responsibility, equitable distribution and exercise of power, and human dignity are reflected as integral to mental health.

**Flourishing as optimal mental health.** Articulation of mental health as a positive phenomenon continues today, most notably in the work of Keyes (2007a; 2007b; 2005; 2003; 2002), who studies “flourishing” – or optimal mental health. Keyes and Haidt (2003: 6) describe flourishing this way:

“Flourishing...exemplifies mental health. Not only are flourishing individuals free of mental illness, they also are filled with emotional vitality and they are functioning positively in the private and social realms of their lives...[F]lourishing individuals are truly living rather than merely existing.”

For Keyes, mental health is a complete state in which there is both the absence of mental illness *and* the presence of flourishing; thus efforts are required to both prevent illness and promote optimal well-being. Curing illness alone will not guarantee a mentally healthy population (Keyes, 2007a; 2007b).

Like Epp (1988), Keyes conceptualizes mental health and mental illness as existing on separate continua. The mental health continuum moves from the absence of mental health (“languishing”) to optimal mental health (flourishing). People who are languishing are neither mentally ill nor mentally healthy; rather, they are living lives

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<sup>4</sup> Cognitive: “perceiving the cognitive the world around us, learning new things, remembering past experience, and using reason and imagination”;

Affective: the full range of human moods, feelings, and emotions;

Relational: the ways in which people interact with one another or with their environment” (Epp, 1988: 4).



of despair, “running on empty,” feeling “hollow” or devoid of positive emotions toward life (Keyes, 2003; Keyes & Haidt, 2003). Languishing is more common in the US population than depression, and it is associated with emotional distress and psychosocial impairment comparable to that of a major depressive episode (Keyes, 2003). For this reason, Keyes argues the presence of languishing is equally as serious and dysfunctional for people as the presence of depression.

At the other end of the spectrum of mental health, flourishing is an individual’s subjective well-being, of which there are several dimensions – emotional well-being (e.g., positive affect, happiness, life satisfaction), psychological well-being (e.g., self-acceptance, personal growth, purpose), and social well-being (e.g., social acceptance) (Keyes, 2003).

Unlike Epp, Keyes focuses mainly on an individual level of analysis and to date has not emphasized the dynamic interaction of people, groups and environment to generate mental health, nor the broader determinants of mental health and mental illness. Thus in Figure 1, below, which depicts the continuum of mental health, elements of Epp’s conceptualization are combined with Keyes’s notion of flourishing to depict a more holistic view of mental health.

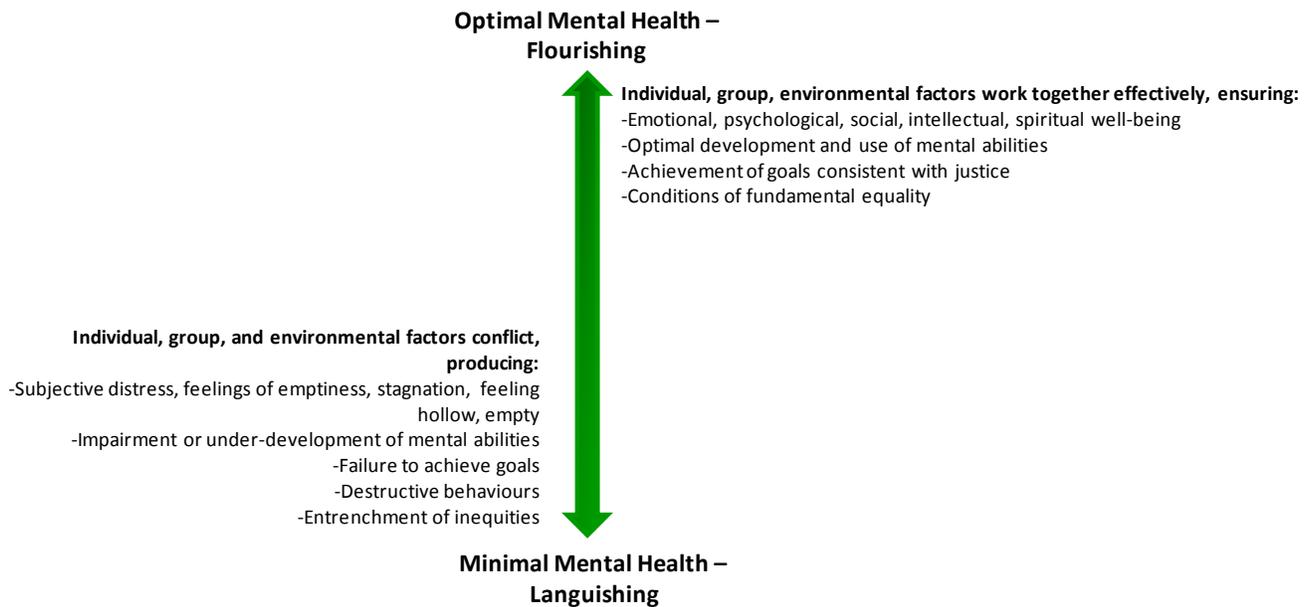


Figure 1. The continuum of positive mental health (flourishing). Adapted from Epp, 1988 and Keyes, 2002.

Importantly, mental health and mental illness cannot be separated; rather, they are coexistent. At any point in time, people can experience various degrees of both mental health and mental illness. The presence of a mental illness does not imply an absence of mental health. People experiencing illness have resources to draw from which can promote their recovery and protect them from worsening illness. Thus positive mental health is important whether or not one is experiencing mental illness (Keyes, personal communication, June 2008; Lahtinen, et al., 2005).

**The determinants of mental health.** Mental health (like mental illness) is influenced by many structural (i.e., societal, cultural, economic, political) factors. Extending well beyond the control of individuals, these structural determinants of mental health enhance or diminish opportunities for individuals, communities and populations to be healthy. They include income and social status, social support networks, education and literacy, employment and working conditions, social environments (e.g., civic vitality), healthy child development, gender, culture, food



security, social inclusion and affordable and adequate housing. See Appendix D for a detailed description of these determinants. *Because of their powerful impact, action on these determinants is foundational to improving mental health.*

An extensive review of literature and research conducted in Australia (Keleher & Armstrong, 2006) identified three central determinants of mental health:

- Social inclusion (supportive relationships, involvement in community and group activities, civic engagement);
- Freedom from discrimination and violence; and,
- Access to economic resources (work, education, housing, money).

**Health inequalities** are particularly powerful determinants of mental health. People and groups who experience material deprivation, poverty, violence, rapid social change, discrimination and other marginalizing conditions are more vulnerable to mental illness (Jané-Llopis & Braddick, 2008; WHO, 2004a). Poverty leads to deprivation in financial, material and/or educational terms, which predisposes people to mental illness. Many believe this is due to inadequate access to health, which leads to stress and feelings of insecurity and hopelessness (Raphael, 2005; WHO, 2004a). In essence, social and material deprivation attenuates mental well-being and predisposes people to mental illness (Keyes, personal communication, June 2008). A vicious cycle begins if mental illness develops since the illness impairs the ability to climb out of a situation of poverty. Ongoing economic and material deprivation thus leads to greater risk for mental illness. These dynamics make addressing health inequalities a central aspect of mental health promotion and mental illness prevention endeavours.

**Global definitions of mental health.** In recent years, many organizations and nations around the globe have developed definitions of mental health. Some of these definitions include:

- Mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections, and personal dignity (Proceedings from the International Workshop of Mental Health Promotion, Centre for Health Promotion, University of Toronto [1997], cited in Public Health Agency of Canada, Online).
- Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation of well-being and effective functioning for an individual and for a community (World Health Organization, 2001).
- Mental health is the embodiment of social, emotional and spiritual well-being. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just (Victorian Health Promotion Foundation, 1999).
- Mental health is not simply the absence of mental disorders but describes “the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice (Australian Health Ministers, 1991)” (Commonwealth Department of Health and Aged Care, 2000: 5).
- Mental health is the state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt and change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. (US Department of Health and Human Services, 1999: 4)



**Key aspects of mental health.** Several key aspects of mental health are consistently identified in the literature:

- **Mental health is the presence of something positive**, such as happiness and satisfaction with one's life. It has multiple dimensions: psychological, emotional, relational/social, intellectual and spiritual. Importantly, mental health is distinct from mental illness. That is, the absence of illness does not imply the presence of mental health. Mental health is, however, a strong protective factor against mental illness (Keyes & Lopez, 2002). Mental health is generated through the ongoing dynamic interplay of individuals, groups and the environment. This implies that improvements to mental health require actions at multiple levels.
- **Mental health is an indispensable ingredient of personal well-being and quality of life, relationships with family and community, and contributions to community and society.** It contributes to society and the economy by increasing social functioning and social capital (Jané-Llopis et al., 2005: 9). Across the lifespan, mental health is the “springboard of communication skills, learning, emotional growth, resilience and self esteem. These are the ingredients of each individual's successful contribution to community and society” (US Department of Health and Human Services, 1999: 4). As such, mental health is a crucial dimension of healthy and productive individuals, families, communities, organizations and societies.
- **Poor mental health is a risk factor for poor physical health, and vice versa.** Depression, social isolation and lack of social support, and prolonged exposure to stress affect the cardiovascular and immune systems, putting people at risk for conditions such as diabetes, high blood pressure, heart attack, stroke and infections (Moodie & Jenkins, 2005; Wilkinson & Marmot, 2003). Conversely, cardiovascular disease can lead to depression (Saxena et al., 2006), and poor mental health affects recovery from physical conditions (WHO, 2004). People with chronic disease suffer markedly higher rates of depression than the general population (WHO, 2004). And poor mental health can reduce the desire to be physically active (Victorian Health Promotion Foundation, 2005a).
- **Mental health is determined to a large extent by social and economic factors;** therefore, success in promoting mental health and well-being can only be achieved through the engagement of and support from the whole community and the creation of partnerships with a wide range of agencies, organizations and sectors (WHO, 2005a: 24).

**Definition of mental health adopted in this paper.** For the purposes of this paper, we define mental health as:

The capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional, social, intellectual and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity (Joubert & Raeburn, 1997). Produced through dynamic interaction between individuals, groups and the broader environment (Epp, 1988), mental health is the foundation of well-being and effective functioning for individuals, families, communities and societies.

## MENTAL HEALTH PROMOTION



Simply defined, mental health promotion (MHP) is “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. [MHP] uses strategies that foster supportive environments and individual resilience while showing respect for culture, equity, social justice, interconnections and personal dignity” (Health Canada, 1997: 4–5). It is an enabling process done by, with and for the people (Hosman & Jané-Llopis, 1999). MHP conceptualizes mental health in positive terms that emphasize strengths, assets, competencies and resources (Pollett, 2007). It aims to enhance mental health through approaches that are collaborative, participatory and empowering (Jané-Llopis, Barry et al., 2005) and which strengthen the innate capacity of individuals, groups and communities to achieve and maintain their own health (Pollett, 2007).

Although related, MHP is not the same as mental illness prevention (see below). Rather, it takes action “to ensure social conditions and factors create positive environments for the good mental health and well-being of populations, communities, and individuals. Mental health promotion requires action to influence determinants of mental health and address inequities through the implementation of effective multi-level interventions across a wide number of sectors, policies, programs, settings, and environments” (Keleher & Armstrong, 2006: 6).

Thus, MHP is characterized by enactment of several key principles:

- Positive conceptualization of mental health
- Emphasis on meaningful engagement and participatory and empowerment-oriented approaches that enable individuals, groups and communities to achieve and maintain their own health
- Emphasis on building upon existing strengths, assets and capacities rather than a focus on problems and deficits
- Collaborative action on the determinants of mental health, particularly action on health inequities
- Multiple interventions across a wide range of sectors, policies, programs, settings and environments
- Approaches that are tailored and culturally appropriate for each group
- Actions informed by evidence and practice

MHP employs many strategies, including those articulated in the *Ottawa Charter for Health Promotion* (WHO, 1986), which include:

- **Building healthy public policy** – development of policies explicitly concerned with health, equity and accountability for health impact
- **Creating supportive environments for health** – creation of spaces where people live, work and play that are supportive of health and/or offer protection from threats to health
- **Strengthening community action for health** – collective efforts to increase community control over health determinants and thereby to improve health
- **Developing personal skills** – enhancement of personal, interpersonal, cognitive and physical skills that help people address the demands of everyday life and thus control their lives and generate change in their environments
- **Reorienting health services** – enhance capacity of health organizations to engage in health promotion

Many effective interventions exist to promote mental health (WHO, Online), some of which include:

- Early childhood interventions (e.g., home visiting, pre-school psychosocial interventions)

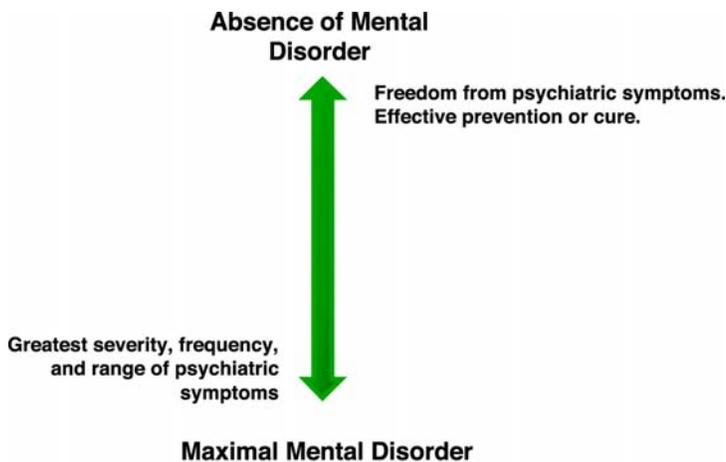


- Support to children (e.g., skill building programs, child and youth development programs)
- Socioeconomic empowerment of women (e.g., improving access to education)
- Social support to older people (e.g., befriending initiatives, community centres)
- Programs targeted at vulnerable groups – minorities, indigenous people, migrants, people afflicted by conflicts and disasters (e.g., psychosocial interventions after disasters)
- Mental health promotion activities in schools
- Mental health interventions at work
- Housing policies
- Violence prevention programs
- Community development programs

MHP is also an important intervention for people experiencing mental illness – its emphasis on existing abilities and capacities can lead to enhanced strength, resilience and self-confidence, and a reduction in dependency on the mental health treatment system (Pape & Galipeault, 2002:3).

## MENTAL ILLNESS

Mental illness, also known as mental disorder, is a “recognized, medically diagnosable illness that results in the significant impairment of an individual’s cognitive, affective, or relational abilities. [Mental illness] results from biological, developmental and/or psychosocial factors and can...be managed using approaches comparable to those applied to physical disease (that is, prevention, diagnosis, treatment, and rehabilitation)” (Epp, 1988: 5).



A mental health problem is “a disruption in the interactions between the individual, the group and the environment” (Epp, 1988: 5). Mental health problems interfere with cognitive, affective or relational abilities but to a lesser extent than mental illness. They are more common complaints, less severe and of shorter duration than mental illness and often occur in response to life stressors (Commonwealth Department of Health and Aged Care, 2000a: 5).

As described above, mental illness is discontinuous with mental health. In the continuum of mental illness (see Figure 2), the absence of mental disorder represents the optimal pole, and at the other end of the spectrum is the presence of severe disorder.

Figure 2. The continuum of mental illness (Epp, 1988)

**Risk and protective factors:** Considerable research exists regarding the nature of risk and protective factors for mental illness. Commonly identified risk and protective factors are presented in the table below.

**RISK AND PROTECTIVE FACTORS POTENTIALLY INFLUENCING THE DEVELOPMENT OF MENTAL HEALTH**



PROBLEMS AND MENTAL DISORDERS IN INDIVIDUALS (Adapted from Saxena, 2006: 7; WHO, 2004: 21)			
RISK FACTORS		PROTECTIVE FACTORS	
<p><b>Biological</b></p> <p>Chronic insomnia</p> <p>Chronic pain</p> <p>Early pregnancies</p> <p>Genetic risk factors</p> <p>Low birth weight</p> <p>Medical illness</p> <p>Neurochemical imbalance</p> <p>Perinatal complications</p> <p><b>Psychological</b></p> <p>Academic failure and scholastic demoralization</p> <p>Attention deficits</p> <p>Communication deviance</p> <p>Emotional immaturity and dyscontrol</p> <p>Excessive substance use</p> <p>Loneliness</p> <p>Handicaps</p> <p>Social Incompetence</p> <p><b>Social</b></p> <p>Displacement</p> <p>Isolation and alienation</p> <p>Lack of education, transport, housing</p> <p>Neighbourhood disorganization</p> <p>Poor work skills &amp; habits</p> <p>Reading disabilities</p>	<p><b>Social (Con't)</b></p> <p>Peer rejection</p> <p>Poor social circumstances</p> <p>Poor nutrition</p> <p>Poverty</p> <p>Racial injustice and discrimination</p> <p>Social disadvantage</p> <p>Urbanization</p> <p>Work stress</p> <p>Unemployment</p> <p>Caring for people who are chronically ill or who have dementia</p> <p>Child abuse and neglect</p> <p>Elder abuse</p> <p>Exposure to aggression, violence and trauma</p> <p>Access to drugs and alcohol</p> <p>Family conflict or family disorganization</p> <p>Low social class</p> <p>Parental mental illness</p> <p>Parental substance abuse</p> <p>Personal loss – bereavement</p> <p>Stressful life events</p> <p>Substance use during pregnancy</p>	<p><b>Psychological</b></p> <p>Ability to cope with stress</p> <p>Ability to face adversity</p> <p>Adaptability</p> <p>Autonomy</p> <p>Early cognitive stimulation</p> <p>Exercise</p> <p>Feelings of security</p> <p>Feelings of mastery and control</p> <p>Literacy</p> <p>Positive attachment and early bonding</p> <p>Problem-solving skills</p> <p>Pro-social behaviour</p> <p>Self-esteem</p> <p>Skills for life</p> <p>Social and conflict-management skills</p> <p>Socioemotional growth</p> <p>Stress management</p> <p><b>Social</b></p> <p>Empowerment</p> <p>Ethnic minorities integration</p> <p>Positive interpersonal interactions</p> <p>Social participation</p> <p>Social responsibility and tolerance</p>	<p><b>Social (Con't)</b></p> <p>Social services</p> <p>Social support and community networks</p> <p>Safe maternal behaviour during pregnancy</p> <p>Good parenting</p> <p>Positive parent–child interactions</p> <p>Social support of family and friends</p> <p>Mental health–promoting schools and workplaces</p>

**Risk factors** are those aspects of an environment that are associated with an increase in the likelihood that people will develop a mental illness. Risk factors can also worsen existing conditions. They include genetic, biological, behavioural, psychological, sociocultural, economic (e.g., poverty) and demographic characteristics (Commonwealth Department of Health and Aged Care, 2000a).



**Protective factors** are those which reduce the likelihood that a person will experience a mental illness. They foster resilience in the face of adversity. This may occur through reducing the exposure to risks, or mitigating the effects of risk factors (Commonwealth Department of Health and Aged Care, 2000a: 13). When the number of protective factors that individuals, groups or communities experience outnumbers the risk factors they experience, the level of risk for developing mental illness is lowered (Resnick et al., 1997, cited in Commonwealth Department of Health and Aged Care, 2000a: 13).

## MENTAL ILLNESS PREVENTION

Mental illness (disorder) prevention “focuses on reducing risk factors and enhancing protective factors associated with mental ill-health, with the aim of reducing risk, incidence, and prevalence and recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected persons, their families, and society” (Jané-Llopis et al., 2006: 7).

Mental illness prevention (MIP) strategies are often categorized in terms of the breadth of focus, ranging from universal to selective and indicated interventions (Mrazek & Haggerty, 1994), which Herrman and Jané-Llopis (2005: 43) define as:

- “Universal interventions – are directed to the whole population and include, for example, school-based interventions or policy actions like taxation of harmful addictive substances, at the population level.”
- “Selective interventions – are targeted to vulnerable groups or sub-groups of the population with risks significantly above average, including, for example, interventions to provide family support for young, [low-income], single, first-time pregnant women.”
- “Indicated interventions – are targeted at high-risk individuals who already experience minimal but detectable symptoms of a mental disorder, including, for example, interventions to promote the coping strategies and support of individuals with symptoms of depression or anxiety.”

In the following pages, a review of policies and plans developed by other nations to tackle the growing burden of mental illness and to enhance the positive mental health of their citizens is presented. The review and subsequent analyses provide insight into the factors and dynamics that enable and constrain successful development and implementation of national-level mental health promotion and MIP policies and strategies.



## MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION IN OTHER JURISDICTIONS

In this section, overviews of mental health, and particularly mental health promotion and mental illness prevention (MHP & MIP), policies and strategies in other jurisdictions are provided. Detailed chronologies and reviews of jurisdictions can be found in *Toward Flourishing for All, Companion Document: Mental Health Promotion and Mental Illness Prevention Policy in International Jurisdictions*.

Findings are organized according to five key aspects of policy development and implementation. These aspects include:

- **Policy development processes** – Who led the policy process? Who participated in development of the policy and how was this process facilitated?
- **Policy design** – How is the policy structured? Are MHP & MIP integrated into a broader mental health policy, or are they “stand alone” policies? In what sector is the policy located – mental health? public health?
- **Policy content and focus** – What is the substance of the policy? How is mental health conceptualized? What is the vision? What are the goals and objectives? What strategies or actions are outlined? To what extent are the key aspects of MHP & MIP apparent in the policy/plan?
- **Policy implementation** – What mechanisms are in place to ensure effective implementation of the policy?
- **Policy monitoring and evaluation** – What mechanisms are in place to monitor policy implementation and evaluate impacts?

### AUSTRALIA

Australia’s first national mental health policy was endorsed by the Australian Health Ministers in 1992. A response to challenges in transitioning to community-based mental health services, this policy focused primarily on mental illness, although MHP & MIP were mentioned. It was soon realized, however, that MHP & MIP were essential elements of a national strategy. In 2000, a stand-alone MHP & MIP action plan – *The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (Commonwealth Department of Health and Aged Care, 2000b) – was developed.

Australia has been a leader in MHP around the globe; many other jurisdictions, including England, Scotland and Ireland, have used its MHP & MIP policies and programs as a guide for their own actions. Parham (2008: 1) has noted, however, that the pendulum in mental health has swung back to early intervention and treatment, and much of the momentum for MHP & MIP gained in the early years of mental health policy in Australia has been lost.



<b>DESIGN &amp; DEVELOPMENT: <i>National Action Plan for Promotion, Prevention &amp; Early Intervention for Mental Health</i></b>
<ul style="list-style-type: none"><li>▪ A MHP &amp; MIP-specific action plan under the <i>National Mental Health Strategy</i> and the <i>Second National Mental Health Plan</i></li><li>▪ Action plan was developed by experts in MHP &amp; MIP and through subsequent consultation with representatives from a range of sectors, consumers, carers and community groups</li></ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"><li>▪ Primary objectives: enhance social and emotional well-being among populations and individuals; reduce the incidence, prevalence and effects of MH problems and disorders; and improve the range, quality and effectiveness of population health strategies for MHP &amp; MIP</li><li>▪ Population health approach; lifespan approach and also targets individuals, families, communities experiencing adverse life events; rural and remote communities; aboriginal peoples; people from diverse cultural and linguistic backgrounds; and strategic priority groups</li><li>▪ Highly detailed plan that outlines desired outcomes, specific actions, rationale for actions, expected outcomes for each group, linkages to other policies, national actions and research questions</li></ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"><li>▪ Implementation of MHP plan was the responsibility of the Mental Health Promotion and Prevention Working Party – but this body was dissolved in 2007</li><li>▪ Implementation also supported by Auseinet (Australian Network for Promotion, Prevention and Early Intervention for Mental Health)</li><li>▪ Advice and coordination is provided by the National Public Health Partnership Group</li><li>▪ National Mental Health Working Group (responsible for oversight of the <i>Second National Mental Health Plan</i>) provides progress reports on the plan</li></ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"><li>▪ National Mental Health Working Group is responsible for overall monitoring and evaluation of the Second National Mental Health Plan, under which the MHP &amp; MIP plan falls – it provides progress reports on the MHP &amp; MIP plan to the Commonwealth, State and Territory Health Ministers</li><li>▪ National Mental Health Working Party has responsibility for monitoring and evaluation</li></ul>



## VICTORIAN HEALTH PROMOTION FOUNDATION

The Victorian Health Promotion Foundation, commonly referred to as VicHealth, is a statutory authority with all-party state political support in the Australian state of Victoria. It has an independent chair and board of governance. Victoria’s Minister of Health is responsible for VicHealth’s performance. VicHealth is internationally recognized as a leader in MHP and for its *Framework for the Promotion of Mental Health and Wellbeing* (Victorian Health Promotion Foundation, 2005a) (see Companion Document).

<b>DESIGN &amp; DEVELOPMENT</b>
<ul style="list-style-type: none"> <li>▪ Three year action plans specific to MHP within context of broader Australian MH strategy and plans</li> <li>▪ First plan developed in collaboration with over 100 key stakeholders, policy-makers and funding bodies, including multiple individuals and groups across many sectors (e.g., sport, arts, education, community health, legal and corporate sectors and national, state and local government)</li> <li>▪ First plan involved mapping key international, national and state activity in MHP, review of evidence and development of an MHP framework to guide innovations, which is now internationally recognized</li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ VicHealth MHP objectives: increase evidence base for MHP in order to advance policy, practice and advocacy activities; develop skills and resources to sustain MHP activity; consolidate MHP activities across sectors; increase broader community understanding of the determinants of MH</li> <li>▪ Priorities for 2005–2007 action plan include rural, indigenous and culturally diverse communities and young people.</li> <li>▪ Areas for investment and activity with these groups include promoting social inclusion, addressing violence and discrimination, increasing access to economic resources and building capacity for MHP</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>▪ VicHealth supports implementation of activities identified in its action plans through purchasing or commissioning programs and projects, brokerage to ensure innovative and collaborative funding models, and advocacy and communication to ensure MHP initiatives are undertaken</li> </ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"> <li>▪ VicHealth supports evaluation of activities in various ways, including development of evaluation strategies and of an indicator set for positive mental health</li> </ul>



## NEW ZEALAND

New Zealand has had a national mental health policy since 1994. Like in Australia, a key thrust of this policy was to develop a framework for deinstitutionalization of mental health services. An extensive collaborative process yielded a framework for MHP in 2002 – *Building on Strengths* – but this is rarely mentioned in other mental health policies or reports and does not appear to be part of core mental health policy (Ball, 2006). Recent efforts in MHP include development of a national *Charter for Mental Health Promotion*. Aspects of the current policy – *Te Tahuhu, Improving Mental Health 2005–2015*, and *Te Kokiri*, the current action plan, are provided in the table below.

<b>DESIGN &amp; DEVELOPMENT – <i>TE TAHUHU: IMPROVING MENTAL HEALTH 2005–2015 &amp; TE KOKIRI: THE MENTAL HEALTH AND ADDICTION ACTION PLAN 2006–2015</i></b>
<ul style="list-style-type: none"> <li>▪ MHP &amp; MIP incorporated into national MH strategy that outlines 10 challenges for MH. First challenge is MHP &amp; MIP; policy development process not stated</li> <li>▪ An MHP &amp; MIP-specific policy, <i>Building on Strengths</i>, was developed in 2002, but appears not to have been implemented</li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ <i>Te Tahuhu 2005–2015</i> strategy re. MHP &amp; MIP includes: <ul style="list-style-type: none"> <li>- increasing people’s awareness of how to maintain MH</li> <li>- inclusion of and support for those experiencing mental illness</li> <li>- ensuring people who are discriminated against can receive effective support, protection and redress; suicide prevention</li> <li>- improving understanding of addictive behaviours and use of early interventions to prevent or limit harm</li> </ul> </li> <li>▪ The current action plan, <i>Te Kokiri</i>, calls for a review of <i>Building on Strengths</i> in order to develop a framework that promotes the areas noted above</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>▪ <i>Te Tahuhu</i> strategic plan 2005–2015 implemented via a detailed action plan – <i>Te Kokiri (2006–2015)</i> which was created through collaboration of District Health Boards (DHBs), Ministry of Health and a wide range of sector stakeholders</li> <li>▪ Plan identifies specific actions, key stakeholders, timelines and lead actors</li> <li>▪ Ministry of Health provides overall leadership for monitoring and reviewing implementation, fostering collaboration across all levels of the MH and addiction sector; DHBs provide leadership through roles as planners, funders and providers and by engaging local communities in implementation of the action plan</li> <li>▪ Other groups mentioned as integral to implementation: wider social sector, primary health organizations, professional groups, NGOs and the voluntary sector, families, service users</li> </ul>
<b>MONITORING &amp; EVALUATION</b>



- Ministry of Health sets out formal expectations in DHB accountability documents re: progress toward key actions; it also implements a monitoring plan to oversee implementation of the action plan
- Ministry of Health to report to Cabinet at least annually on progress and delivery of the action plan for 2005–2015; a mid-point evaluation will occur in 2010
- Mental Health Commission monitors performance of the Ministry of Health and the 21 DHBs in implementing the strategy; Commission reports its findings to the government



## EUROPEAN UNION

MHP & MIP has become a priority in European policy, particularly within the last five years, through the actions of key European bodies such as the World Health Organization Regional Office in Europe and the European Commission (EC).

The World Health Organization (WHO): At a 2005 WHO Ministerial Conference on mental health, European health ministers signed the *Mental Health Declaration for Europe* and endorsed the *European Action Plan for Mental Health*; the latter proposes particular actions to enhance mental health in the member states. Details of the action plan are presented in the table below.

<b>DESIGN &amp; DEVELOPMENT – EUROPEAN ACTION PLAN FOR MENTAL HEALTH (WHO, 2005)</b>
<ul style="list-style-type: none"> <li>Stand-alone action plan specific to MHP &amp; MIP; developed initially by WHO with a consultative feedback process; high-level document that recommends actions to member states</li> </ul>
<b>CONTENT/FOCUS</b>
<p>Actions outlined include:</p> <ul style="list-style-type: none"> <li>Promoting mental well-being for all</li> <li>Demonstrating the centrality of MH</li> <li>Tackling stigma and discrimination</li> <li>Promoting activities sensitive to vulnerable life stages (infancy, childhood, youth, old age)</li> <li>Preventing MH problems and suicides</li> <li>Ensuring access to good primary care for MH problems</li> <li>Offering effective care in community-based services for people with severe MH problems</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>By member states, subject to national constitutional structures and responsibilities</li> <li>Member states work in conjunction with relevant national and international stakeholders</li> </ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"> <li>By member states</li> </ul>

**The European Commission:** The European Commission was a key partner of the WHO at the 2005 Ministerial Conference. The Commission’s *Green Paper on Mental Health*, launched in 2005, reflected key themes of the WHO Declaration and Action Plan and proposed a framework for exchange and co-operation between member states, with the aim of engaging a broader range of health and non-health stakeholders in building solutions (Jané-Llopis, 2006). A European strategy for mental health was viewed as a way to mainstream good practice across member states and also to mainstream MHP across fields and sectors (Kosinska, 2006). This collaborative, multi-sectoral approach was new for the EC.



Following up on the consultations of the EC’s *Green Paper*, a European Union (EU) high-level conference in June 2008, Together for Mental Health and Wellbeing, launched the *European Pact for Mental Health and Well-Being*. The reference context for the Pact includes the WHO Declaration. The Pact acknowledges the importance of mental health as a key resource for individuals and success of the EU as a knowledge-based society and economy. It emphasizes four themes for action, each of which is informed by a consensus evidenced-based background paper (see the table below).

In effect, the EC has a greater mandate in Europe with member states than does WHO, as when measures are passed at the EC’s Council of Ministers, they become more mandatory at the country level than when established through a Ministerial Conference of the WHO. Countries adopt statements such as the European Pact for Mental Health and Well-Being through their legislative processes (i.e., development of new laws) (Jané-Llopis, personal communication, September 2008).

<b>DESIGN &amp; DEVELOPMENT – EUROPEAN PACT FOR MENTAL HEALTH &amp; WELL-BEING (EUROPEAN COMMISSION, 2008)</b>
<ul style="list-style-type: none"> <li>▪ A pact signed by member states that indicates commitment to actions to promote MH and well-being, particularly regarding five target areas, in support of the WHO <i>Mental Health Declaration for Europe</i></li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ Recognizes MH as a human right that enables citizens to enjoy well-being, quality of life and health</li> <li>▪ Four themes and areas of action are emphasized; each is informed by a consensus, evidence-based background paper: <ul style="list-style-type: none"> <li>- Prevention of depression and suicide</li> <li>- Youth, education and mental health</li> <li>- Mental health and older people</li> <li>- Mental health in workplace settings</li> </ul> </li> <li>▪ A fifth theme, combating stigma and social exclusion, runs through the four areas listed above</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>▪ To be implemented through a series of thematic conferences for each of the key themes during 2009–2010</li> <li>▪ Member States work in conjunction with relevant national and international stakeholders</li> </ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"> <li>▪ By member states</li> </ul>



## ENGLAND

England’s *National Service Framework for Mental Health – Modern Standards and Service Models* was released in 2000. Standard One of the Framework is MHP. The document *Making It Possible: Improving Mental Health and Well-Being in England* (NIMHE, 2005) supports the requirement of Standard One. *Making it Possible* presents “good practice” to support the development and delivery of MHP actions and sets out a framework for action to raise public awareness of how people can look after their own mental health and to involve all communities and organizations across all sectors to take positive steps toward promoting and protecting mental health. Relevant aspects of the *National Service Framework* and *Making It Possible* are outlined in the table below.

<b>DESIGN &amp; DEVELOPMENT – NATIONAL SERVICE FRAMEWORK &amp; MAKING IT POSSIBLE</b>
<ul style="list-style-type: none"> <li>▪ Mental health policy that integrates MHP &amp; MIP</li> <li>▪ Developed with advice from an external reference group, which brought together health and social care professionals, service users and carers, health and social service managers, partner agencies and other advocates</li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ Sets out five evidence-based standards for MH and includes examples of good practices for each standard</li> <li>▪ The aim of Standard One – MHP – is “to ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems” (NHS, 1999: 14)</li> <li>▪ <i>Making it Possible</i> supports Standard One and commitments in another government document to ensure this standard is fully implemented; local priorities for action are to be determined by local needs-assessment informed by evidence of effectiveness; the document highlights areas where there is a strong case for action, including: <ul style="list-style-type: none"> <li>- Marketing MH</li> <li>- Equality and inclusion</li> <li>- Violence and abuse</li> <li>- Early years</li> <li>- Schools</li> <li>- Employment</li> <li>- Workplace</li> <li>- Communities</li> <li>- Older people</li> </ul> </li> <li>▪ Each of the above is described in detail, including evidence for action and indicators of success; a model for improving MH is outlined, based on the premise of mainstreaming MHP into public health.</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>▪ The National Institute for Mental Health in England (NIMHE) was established to support implementation of the <i>National Service Framework for Mental Health</i>; the NIMHE has eight development centres, aligned with England’s eight health authorities, and each centre supports implementation of the Framework in its respective region.</li> </ul>



<b>MONITORING &amp; EVALUATION</b>
NIMHE (as above)

## REPUBLIC OF IRELAND

There has been increasing recognition at policy and practice levels within Ireland of the importance of MHP & MIP. MHP experts have been advocating for a specific MHP strategy for the Republic with the belief that a specific MHP policy framework would help coordinate efforts and guide delivery of best practices. Suicide-prevention efforts have also resulted in calls for MHP and primary prevention strategies. This has not yet come to fruition, but MHP has been integrated into the Republic’s new national mental health policy, *A Vision for Change* (Department of Health and Children, 2006). Pertinent details of this policy are presented in the table below.

<b>DESIGN &amp; DEVELOPMENT – <i>A VISION FOR CHANGE</i></b>
<ul style="list-style-type: none"> <li>▪ National MH policy that integrates MHP &amp; MIP; an entire chapter of the policy is devoted to MHP</li> <li>▪ Developed by an expert group drawn from all the MH professions, voluntary groups and service users. An extensive consultation process was undertaken in preparation of the policy, including publication of requests for written submissions, circulation of a survey seeking the views of consumers currently using the system, a study of in-patients, and 19 advisory subgroups to provide detailed input on various aspects of the document. Over 100 individuals, including consumers and carers, were involved in this process.</li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ <i>A Vision for Change</i> proposes a holistic view of mental illness and recommends an approach that addresses individual and social factors that contribute to mental illness</li> <li>▪ Chapter regarding MHP highlights the promotion of positive MH via a population-health framework and recommends:             <ul style="list-style-type: none"> <li>- MHP should be incorporated into all levels of MH and MH services</li> <li>- A framework for interdepartmental co-operation cross-cutting health and social policy</li> <li>- Designated health promotion officers should have responsibility for MHP</li> <li>- Training and education programs should be put into place to develop capacity and expertise for evidence-based prevention and promotion</li> </ul> </li> <li>▪ Four key issues: promoting positive MH and well-being; raising awareness of the importance of MH; enhancing the capacity of MH service providers and the general community to promote positive MH; suicide prevention – through a lifespan approach</li> <li>▪ In addition, MHP/MIP strategies aimed at increasing resilience and decreasing risk factors are integrated throughout the policy document</li> <li>▪ Policy also includes chapters on partnerships and social inclusion</li> </ul>



<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"><li>▪ Responsibility for development and implementation of MH policy and practice rests with the Department of Health and Children and the Health Service Executive at the national and regional levels</li><li>▪ The policy recommends an implementation review committee to oversee its implementation; however, a statement from Mental Health Ireland in 2007 indicated disappointment in failure of the Health Services Executive to appoint a National Mental Health Service Directorate, a key recommendation of the expert group that developed A Vision for Change (Mental Health Ireland, 2007)</li></ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"><li>▪ Department of Health and Children and Independent Monitoring Group.</li></ul>



## SCOTLAND

The Scottish Executive’s<sup>5</sup> vision of “an open, just and inclusive Scotland where respect and understanding are fostered and where everyone is encouraged and enabled to live, work and take part in society to their full potential, free from prejudice and discrimination” (Scottish Executive, 2003a) gives insight to the focus and orientation of Scotland’s government. Mental health and well-being are linked to the Executive’s wider work on promoting equality and improving health in Scotland. Although the nation’s national mental health promotion program has only been in effect for eight years, it has become internationally recognized as an “exemplar of policy development and implementation in public mental health” (NHS Health Scotland, 2008: 12).

The vision of the program is “to improve the mental health and well-being of people living in Scotland and to improve the quality of life and social inclusion of those who experience mental health problems” (NHS Health Scotland, 2008: 9).

<b>DESIGN &amp; DEVELOPMENT</b>
<ul style="list-style-type: none"> <li>▪ An integrated strategic approach to public MH that is part of an overall public health and health-improvement strategy</li> <li>▪ Developed in collaboration with numerous stakeholders, as are action plans</li> </ul>
<b>CONTENT/FOCUS</b>
<ul style="list-style-type: none"> <li>▪ Four key aims 2003–2006 and consolidated during 2006–2008: raising awareness and promoting MH; eliminating stigma and discrimination; preventing suicide; and promoting and supporting recovery</li> <li>▪ Six priority areas: improving MH in infants, in children &amp; young people, in working life, in later life, and in communities; and improving MHP &amp; MIP in local services</li> <li>▪ Program provides supports to national and local agencies through ongoing collection and dissemination of research on MHP; supporting and commissioning evaluation of the program; development of a core set of public mental health indicators, communication strategies, learning networks and training opportunities</li> </ul>
<b>IMPLEMENTATION</b>
<ul style="list-style-type: none"> <li>▪ Implemented through three-year action plans; consultation currently underway to develop second stage of work following independent review of first stage</li> <li>▪ National Advisory Group 2001–2006 advised Scottish Executive ministers on development and implementation of the program’s action plan and provided leadership, encouraged commitment and provided coordination; replaced by a National Reference Group to help advise on the next framework and action plan (due December 2008)</li> <li>▪ The work adopted Kotter’s (1995) eight-point transformational change model to inform planning and implementation efforts</li> <li>▪ National Programme Team created to lead the coordination and implementation of the program</li> </ul>

<sup>5</sup> The Scottish Executive became the Scottish Government with the new government formed in May 2007.



<ul style="list-style-type: none"><li>▪ Funding for MHP from public health and health improvement funds</li><li>▪ Support to and funding of research, evidence, and dissemination</li></ul>
<b>MONITORING &amp; EVALUATION</b>
<ul style="list-style-type: none"><li>▪ Independent expert review panel conducted an evaluation at end of first action plan in 2006 and reported in 2008</li><li>▪ Scotland has created an extensive set of national public mental health indicators, which also include a population survey measure of positive mental well-being (the Warwick Edinburgh Mental Wellbeing Scale)</li></ul>



## SUMMARY

Highlights of MHP & MIP policy in international jurisdictions are presented in the table below.

SUMMARY OF MHP & MIP POLICY IN INTERNATIONAL JURISDICTIONS				
JURISDICTION	DESIGN & DEVELOPMENT	CONTENT/FOCUS	IMPLEMENTATION	MONITORING & EVALUATION
<b>Australia</b>	Specific MHP & MIP action plan under the national policy; consultative development process	MHP, MIP, early intervention	Govt. MHP & MIP body; Auseinet	Govt. MHP & MIP body
<b>VicHealth (Australia)</b>	Action plan specific to MHP within context of broader Australian MH Strategy and Plans; collaborative development (and implementation) process	MHP; strong orientation to building capacity and evidence base for MHP; increasing community understanding of the determinants of MH	Responsibility for implementation is “collaborative”	Collaborative efforts
<b>New Zealand</b>	MHP & MIP integrated into national plan; a stand-alone MHP & MIP plan that is not referenced	Increasing awareness of MH, inclusion and support for MI, anti-discrimination, suicide prevention, early interventions and prevention of addictions	District Health Boards	Ministry of Health
<b>European Union</b>	Specific to MHP & MIP	EU Pact outlines five key areas: workplace, youth & education, older people, suicide prevention, stigma & exclusion	By each member state	By each member state
<b>England</b>	MHP & MIP integrated into a national policy; <i>Making it Possible</i> outlines supports to MHP aspect of the policy.	<i>Making it Possible</i> provides “good practice” to support development and delivery of MHP actions	National Institute for Mental Health in England (NIMHE) office in each health region to support implementation	NIMHE office in each health region; development of national MH indicators

<b>Ireland</b>	MHP & MIP integrated into national MHP policy	Promoting positive MH, raising awareness of the importance of MH, enhancing capacity of MH service providers and general community to promote positive MH; suicide prevention	Department of Health and Children, and the Health Service Executive at national and regional levels	Department of Health and Children and Independent Monitoring Group
<b>Scotland</b>	Integrated approach to MH – part of overall public health and health improvement strategy; developed via extensive collaboration	MHP, stigma and discrimination, suicide prevention, promoting recovery	Initially a National Programme Team; now a Reference Group to advise on next framework and action plan	Development of national public MH indicators

## KEY SUCCESSSES AND CHALLENGES EXPERIENCED BY OTHER JURISDICTIONS IN DEVELOPING AND IMPLEMENTING MHP & MIP POLICY

The findings reported below are primarily based on analysis of evaluation data that was found for Australia, New Zealand and Scotland, as well as anecdotal evidence provided in the documentation of other jurisdictions and interviews with key informants. Most of these findings indicate increased understanding of and investment in actions to enhance positive mental health and prevent mental illness in communities, other sectors and government.

### Successes

- **International recognition for leadership in MHP & MIP** (Australia, VicHealth [Australia], Scotland) which adds leverage to efforts and helps secure funding and other resources
- **Shifts in government understanding of, and commitment to, positive mental health, MHP & MIP**
  - MHP program an important focal point within government in terms of its role as a source of help, support, and information on mental health improvement (Scotland)
  - Mental health improvement is no longer viewed as a marginal aspect of health policy (Scotland, EU)
  - Recognition of the value of, and prioritization of population health approach at high levels of government (Australia, New Zealand [NZ], Scotland, EU)
- **Acceleration of the change process** through allocation of resources for MHP & MIP and injection of energy and enthusiasm
  - **Increased funding** (Australia, NZ, Scotland), and commitment to sustaining adequate funding for mental health (Australia)
  - MHP program **injected new energy** into mental health policy, generating creativity, commitment and enthusiasm; MHP now seen as an area of innovation and fostering new possibilities for change (NZ, EU)



- **Multi-sectoral collaboration to promote mental health** and ownership of MHP & MIP by other sectors (VicHealth, EU, Scotland)
  - Funding has leveraged **changes in human service systems outside the health sector** – e.g., housing and employment (Australia, VicHealth [Australia])
  - Extensive consultation processes in VicHealth, the EU, and Scotland – based on reaching a common understanding of “mental health” – have been successful in engaging new sectors (e.g., business, education, art, sports) in prioritization of issues at the policy level
- **Enhanced capacity for MHP & MIP**
  - **Development of an evidence-based approach** to mental health improvement (Australia, VicHealth [Australia], EU, England, Scotland, Ireland)
  - **Development of a skilled MHP & MIP workforce** (VicHealth [Australia], NZ, Scotland, EU, Ireland)
- **Action and results on the ground**
  - An **impressive list of national, state/territorial and local initiatives** that have focused on MHP & MIP (Australia, VicHealth [Australia], Scotland, EU)
  - **Successful anti-stigma and anti-discrimination programs** (VicHealth [Australia], NZ, Ireland)
  - **Increased mental health literacy** of the public (Australia, NZ, Scotland), and growing recognition that mental health is everybody’s business (Australia, EU)
  - **Increased community interest and involvement in mental health** (Australia, NZ, VicHealth [Australia], Scotland, EU)

### *Challenges: Turning Policy into Action*

All of the challenges experienced by other jurisdictions pertain to the need for a stronger infrastructure to support policy and action plan implementation. These include:

- **Need for strong leadership in government and a powerful guiding coalition** to:
  - champion positive mental health, MHP & MIP;
  - communicate the policy vision to front line staff and help others to act on the vision; and,
  - coordinate cross-government and cross-sector collaboration (Australia, NZ, Scotland)
- **Need for a shared vision of positive mental health within health and across sectors** and of MHP & MIP (NZ, Scotland). Reviewers of the *Scottish National Programme*<sup>6</sup>, for example, recommended facilitation of multidisciplinary discussion and experiential learning to develop a common language and common understanding of mental health and well-being. In New Zealand

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<sup>6</sup> Scotland has enjoyed many successes on this front; the evaluation noted, however, that further and ongoing efforts will be required in this regard.



it was noted that the individual medical model dominates the health sector, making it difficult to gain commitment and funding for MHP & MIP.

- **Need for greater accountability** in the form of clear roles and responsibilities for implementation (Ireland)
- **Facilitating meaningful participation of other sectors** – this was cited as the area that most needs strengthening in Australia (Parham, 2005). All jurisdictions, moreover, cited this as a challenge. The need to have all sectors and levels of society understand the mental health impact of their actions and to realize that many of the risk factors and protective factors for mental health exist in the conditions of everyday life was also pointed out in evaluation of policy in Australia (Commonwealth Department of Health and Ageing, 2003).
- **Integrating MHP & MIP policies and plans with existing programs** and organizations to avoid overlap and add value, and the need for greater collaboration and cross-fertilization between initiatives
  - Confusion about how multiple policies and action plans fit together (Australia)
  - Weaknesses in cross-government and cross-sectoral collaboration (Australia, NZ, Scotland)
  - Confusion about roles and responsibilities for MHP & MIP within the mental health sector (Australia)
  - Thus, a need for a coherent and overarching framework through which the linkages between policy, action and research at various levels are made explicit, and through which information and knowledge are readily shared (Australia, NZ)
- **Integrating MHP & MIP into public health** (Australia, Scotland). The potential for the expertise of public health to enhance MHP & MIP work (and vice versa) is untapped.
- **Insufficient resources for implementation**
  - Need for dedicated funding for MHP & MIP (Australia, NZ, Ireland)
  - Training – need to enhance technical skills and competencies required to support MHP policy activities (Scotland); need to move beyond short workshops (NZ)
  - Need for a sustainable workforce strategy (Scotland)
  - Need to extend knowledge about effective approaches (Australia, VicHealth [Australia], Scotland)
- **Regression to policy focused on treatment and services.** A greater emphasis on treatment and service delivery is apparent in Australia, due in part to strong consumer dissatisfaction with treatment services. In New Zealand, an MHP & MIP-specific policy has not been implemented and is seldom referred to in government documentation.
- **Variable execution of policy and action plans** across states/territories despite clear and appropriate policy direction. In Australia, the only jurisdiction with the same levels of government as Canada, policy direction is strong at the national level, but less consistent at the state/territorial level.
- **Addressing inequalities, cultural diversity and gender issues** (Scotland)
- **Ensuring evaluation is part of continuous quality assessment** (Scotland)



These successes and challenges in developing and implementing MHP & MIP policy will be elaborated upon in the Analysis and Discussion section of the paper.



## STRATEGIES TO REDUCE THE IMPACT OF SOCIETAL TRENDS ON MENTAL HEALTH

Mental health is in large part about coping with the challenges of life – and, as the Government of Newfoundland and Labrador (2001: 3) notes, “no one gets through life without such challenges.” Indeed, Canadians and the global community face many challenges that threaten mental health: economic uncertainty, rising fuel and food prices, global warming and environmental degradation, threats of terrorism and pandemic influenza, a culture of consumerism and individualism, and the growing gap between rich and poor. For those experiencing social and economic disadvantages, these threats are even more distressing.

A key aim of this document is to explore how other jurisdictions have used national-level MHP & MIP strategies to address or reduce the impact of social trends and environmental changes associated with increased risk of mental distress. The review of MHP & MIP policies in international jurisdictions provided little evidence of policies or strategies specifically targeted at these challenges; rather, the MHP & MIP efforts described were of a broad nature, seeking to enhance mental health at individual, community and population levels. Since MHP & MIP-specific policies are relatively new in and of themselves, these issues may not yet have been integrated into thinking at the policy-development level.

At a broader level, however, it can be said that MHP addresses these issues through approaches that strengthen resilience, promote stronger and healthier communities, and address the structural determinants of health, including some of those described above. MHP presents an optimistic approach to tackling these challenges, adopting the view that empowered, connected people who benefit from health-promoting environments and policies can deal effectively with challenges and in so doing, experience positive mental health. This is clearly exemplified in New Zealand’s draft *Mental Health Promotion Charter*:

“Mental health promotion takes the positive stance that strong people who are in control of their destinies, who are connected with each other through their communities and cultures and who have the benefit of enlightened social policy enacted by governments and organizations have the power to deal effectively with these issues and thereby to enhance their own capacity and connectedness, and changing their life situations, in a healthy and satisfying way, which in turn leads to optimal mental health for all” (New Zealand Mental Health Promotion Advisory Group, 2008: 8).

A caution, however, is that over-reliance on building resilient individuals and communities without attention to the structural determinants of mental health – the factors that underlie causes of mental distress – may be counterproductive. The major thrust of MHP is to address structural barriers to mental health rather than merely preparing people to cope with increasing threats to their well-being.

Not generally referenced in “everyday MHP,” however, are the threats to mental health imposed by human-made and natural disasters. Weiss et al. (2003) argue that while it may not be necessary to systematically differentiate between natural and human-made disasters when formulating national mental health policy, attention should be paid to distinguishing ongoing situations [war, drought] with time-limited and acute disasters [hurricane, terrorist attack]. At the international level, these threats are being taken into consideration. For example, the Inter-Agency Standing Committee (an international group of the heads of United Nations and non-UN humanitarian organizations) published a set of guidelines on mental health and psychosocial support in emergency settings in 2007 (IASC, 2007). The World Federation for Mental Health hosted an International Forum on Mental Health and Psychosocial Support



in Emergency Settings in August 2008 to promote adoption and use of the IASC guidelines. A number of issues regarding the need for greater collaboration and coordination among humanitarian relief organizations and grassroots mental health organizations in responding to mental health support needs of people and communities affected by natural and human-made disasters and emergency situations will be addressed (World Federation for Mental Health, Online).

Two essential components to the development of mental health policy to respond to these threats have been identified as, first, addressing the needs of the individuals requiring support and treatment, and second, addressing the need for social revitalization and community reconstruction (Weiss et al., 2003). Hence, MHP & MIP strategies can prove very useful in addressing either of these two components by enhancing resilience, promoting social inclusion and creating policies that address health inequities. This is a critical element to MHP/MIP policy in Canada, because it relates to promotion of mental health in an increasingly diverse and aging population.

Particularly important for Canadian policy-makers is the need to acknowledge that global trends and events influence Canadian society. Victims of environmental disasters, increased conflict and war, and economic pressures in other jurisdictions may become part of Canada's growing immigrant and refugee population. To ensure that mental health policies and programs for these populations are accessible, appropriate and effective, it is imperative to understand the complexity of the pre- and post-migration context and to pay attention to the social conditions (e.g., unemployment, family violence, discrimination) that may affect the physical and mental health of these newcomers to Canada.



## ANALYSIS AND DISCUSSION

In this section, analysis of the review findings (jurisdictional review, key informant interviews and literature) and discussion regarding their application to the Canadian context are presented. The findings and discussion are organized around five central aspects of policy development and implementation processes:

- Collaborative action for MHP & MIP policy development and implementation
- Policy design
- Policy content
- Policy implementation
- Policy monitoring and evaluation

Each section begins with a brief introduction, followed by an analysis of policy in other jurisdictions. This analysis is followed by discussion of the implications of the findings for policy action in Canada. Each section is concluded with one or two high-level recommendations and questions for further deliberation.

### COLLABORATIVE ACTION FOR MHP & MIP POLICY DEVELOPMENT AND IMPLEMENTATION

*“The challenge for the coming years will be to unlock the potential for health promotion inherent in many sectors of society, among local communities, and within families.”*  
(WHO, Jakarta Declaration, 1997)

Since the determinants of mental health lie primarily outside the health sector, collaborative action with other sectors, various levels of government and the public at large is fundamental in developing and implementing MHP & MIP policies and plans. Engagement of these key stakeholders presents a “win-win” situation that creates a broader sphere of influence for promoting positive mental health. These stakeholders are already conducting activities that promote (or in some cases, hinder) mental health. They may not be aware of their impact on mental health but can be encouraged to expand their health-promoting work (or cease/modify their health-damaging work) (Moodie & Jenkins, 2005). The keys are to discern shared goals and find synergistic ways to achieve them (Moodie & Jenkins, 2005).

But “other sectors” are not the only key stakeholders; rather, it is the public at large that is the primary stakeholder in promotion and prevention efforts. As such, fostering a grassroots movement to mobilize against the factors that are toxic to mental health and well-being is highly desirable (Friedli, 2005).

### ANALYSIS OF JURISDICTIONS: ENGAGING STAKEHOLDERS IN POLICY DEVELOPMENT AND IMPLEMENTATION

All jurisdictions adopted some form of consultative process in developing and implementing mental health and MHP & MIP policy; some employed more collaborative processes. Successes and challenges associated with engaging stakeholders are elaborated below.



### *Successes experienced by other jurisdictions*

Jurisdictions that developed broad mental health policies (i.e. those that included MHP, MIP and service delivery) typically engaged in consultations with other government sectors, consumers of mental health services and their carers, and service providers (e.g., Australia). In New Zealand, an expert committee developed an initial draft and then consulted with various stakeholders to obtain feedback and further direction.

**Ownership of MHP & MIP by other sectors.** In those jurisdictions with MHP & MIP-specific policies and plans, the process of policy development appears to have been more inclusive and participatory. For example, VicHealth partnered with over 100 individuals and organizations from a broad cross-section of society, including the arts, culture, sport and recreation sectors, to develop its framework for MHP. Engaging these vital stakeholders from the start engendered ownership and responsibility for mental health in organizations and sectors outside of health and this in turn meant access to external resources without diluting funding for service delivery. Similar approaches in Scotland have met with similar levels of success. Although New Zealand's *Building on Strengths* MHP policy hasn't been comprehensively implemented, it was developed through an extensive two-year consultation with key stakeholders (Raeburn, personal communication, June 2008).

The value of inclusive and participatory approaches to policy development is also being recognized by the European Commission. In its most recent efforts, the Commission has avoided a top-down approach and instead opted to “map” helpful information that nations can use to promote mental health. This mapping project involved developing five consensus-based technical reports regarding specific aspects of MHP (e.g., youth, education and mental health; mental health in workplace settings). Key stakeholders were invited to participate in developing these papers. For example, large multinational companies known to be interested in corporate social responsibility and health were invited to work on the *Mental Health in Workplace Settings* consensus document. Engagement of these industry leaders attracted the interest of other businesses. The consensus papers are not prescriptive; rather, they are informative. They present “what is known” in order to help nations see what needs to happen next – what policies and approaches should be emphasized. So far, this approach has been more engaging and generative than the traditional top-down policy development approach (Jané-Llopis, personal communication, June 2008).

A key element of success in these efforts has been a flexible approach to language about mental health, with the recognition that other sectors may use different words – emotional well-being, for example – that are similar in meaning to positive mental health. Rather than imposing a predetermined definition of “positive mental health,” MHP & MIP advocates were careful to discern the language used by other sectors and use that as bridge toward a shared understanding of how “mental health” influences the aims and goals of these other sectors. This shared understanding provided a platform for collaborative action.

**Inclusion and engagement of indigenous peoples.** Special mention must also be made about inclusion of indigenous peoples, who for many reasons experience higher risk of mental health problems, in MHP & MIP policy development. New Zealand and Australia are making significant efforts to include these groups in policy actions. New Zealand has had good success in engaging its diverse population, particularly the Maori people, in the process. A resurgence of Maori identity and the *Treaty of Waitangi* in New Zealand appears to be a driver of these efforts. Its documentation is replete with Maori language, indicating a commitment to inclusion. Progress has also been made in Australia, but evaluations have highlighted the need for increased cultural competency of non-indigenous mental health workers (Commonwealth of Australia, 2002).



### *Challenges encountered by other jurisdictions*

**Fostering meaningful participation of other sectors.** Despite the successes noted above and widespread recognition of the need for inclusive and participatory approaches to mental health policy development and subsequent implementation, fostering meaningful participation of other sectors was identified as an ongoing challenge in all jurisdictions and by key informants. For example, while good progress has been made in Australia, evaluators concluded that more work is needed to extend knowledge about effective approaches and to have all sectors and levels of Australian society consider the mental health implications of their actions (Commonwealth of Australia, 2003). And Parham (2005) noted that despite the energy and commitment of other sectors to address mental health issues, meaningful participation had not been secured – there is a need for mechanisms such as joint planning groups, memoranda of understanding, and collaborative partnerships.

**Collaboration within the mental health sector.** Bridging MHP & MIP efforts with mental health service delivery was identified as a challenge in Australia. Service providers and consumers may view MHP & MIP as a challenge and distraction from service delivery. Evaluators concluded that clarity about the aims of MHP and the utility of a population-health approach is needed, as is clarity of roles – how do MHP & MIP fit within the context of treatment and recovery? Much of the tension between MHP & MIP and mental health service delivery is thought to stem from a lack of resources and competing priorities (Commonwealth of Australia, 2003).

## **DISCUSSION: HOW CAN WE WORK COLLABORATIVELY ACROSS DIFFERENT LEVELS AND SECTORS AND SEGMENTS OF SOCIETY TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS?**

MHP policy development processes should be congruent with the principles and practices of mental health promotion – that is, a participatory, empowerment-oriented approach that conceptualizes mental health in positive terms that emphasize strengths, assets, competencies and resources in ways that build the innate capacity of individuals, groups and communities to achieve and maintain their own health. It has been noted above that, particularly in the experiences of VicHealth and Scotland, engagement of key stakeholders from the beginning has many benefits: buy-in, development of authentic engagement and collaboration, sharing of resources, and an expanded sphere of influence. A shared vision for the positive mental health of Canadians is required to compel action and collaboration. However, this is a complex endeavour especially in developing a national policy in a country as large and diverse as Canada. Careful thought needs to be given to how this can be achieved. Who should be involved? How should the process be facilitated? Will consensus be sought? How? Who takes responsibility?

In this section, several aspects that may inform collaborative efforts in MHP & MIP policy development and implementation in the Canadian context are discussed. This includes discussion regarding facilitating factors, “the art of connecting” and fostering political will.

### *Facilitating Factors*

There are at least three broad factors that facilitate collaborative action for MHP & MIP: the current international momentum for MHP & MIP, societal momentum regarding positive mental health, and the wealth of evidence that supports the effectiveness of MHP & MIP. These can be leveraged to engage



stakeholders in dialogue about positive mental health and the need for MHP & MIP policy and action. Each of these factors is described below.

**International momentum for MHP & MIP.** MHP & MIP is acquiring worldwide recognition and there is growing momentum in policy development, practice and research. In the past five years, much activity has occurred: scientific reviews, development of knowledge networks, and international reports on mental health and prevention of mental illness. The World Health Organization and the International Union for Health Promotion and Education (under the Global Programme on Health Promotion Effectiveness) recently led major reports reviewing the evidence of what works in MHP & MIP (Hosman et al., 2005; Herrman et al., 2005; Jané-Llopis et al., 2005).

**Societal momentum for positive mental health.** Despite rising GDP and increasing levels of material wealth, people in the developed world aren't any happier today than they were in the 1950s (Anielski, 2007). Economic prosperity, once deemed the foundation of happiness, appears to buy only a small amount of that commodity, and there appears to be growing social unrest with this situation. Considerable public and media attention is being paid to mental health-related issues: happiness, life satisfaction, the economics of well-being, and quality of life (NIHME, 2005). And if bookstore shelves are any indicator, there is a growing social preoccupation with these issues – a search in the Chapters.ca website using the term “happiness” yields more than 1800 titles, a large number of which have been published since 2004. This unrest may indicate a public that is hungry for actions to enhance mental health – a significant opportunity for moving MHP & MIP efforts forward on a large scale.

In Canada, Roy Romanow has championed the development of the *Canadian Index of Wellbeing* (CIW), led by an extensive network which includes the country's leading indicator practitioners, experts from Statistics Canada, NGOs across the provinces and territories, and linkages with international experts. The CIW links “the economic reality and longer-term economic prosperity of our country with the social, health and environmental conditions that shape our communities” (Romanow, 2005: 7). It is hoped that the CIW will become a regular feature of reporting in the media, and a driver of policy making processes of governments that are “better aligned with Canadian values” (Romanow, 2005: 8).

The New Economics Foundation, an independent think tank, recently published *A Well-Being Manifesto for a Flourishing Society* (Shah & Marks, 2004). The manifesto calls for creation of a “well-being economy” which includes an education system that promotes flourishing and happy youth and a health system that promotes psychological well-being, strengthening active citizenship and civil society, and social well-being.

A challenge inherent within this opportunity, however, is to move the conception of psychological and social well-being and happiness away from a focus on purely individual and personal matters to something that is strongly influenced by things that extend beyond the individual's control – the social and political factors that shape individual, family, group and community mental health (Sainsbury, 2003). This is also a challenge within the field of positive psychology and others that emphasize strengthening individual and community resilience and other individual protective factors – while it is good to strengthen resilience such that people and communities can cope more effectively with adversity and the challenges of our times, it is crucial that we not lose sight of the need for actions that ameliorate the underlying causes of risk factors and inequalities (Henderson, personal communication, July, 2008).

Beyond the health system, mental health, emotional well-being, and quality of life are implicit or explicit in a broad range of policies and sectors, including those related to education, culture/arts, sports, employment, crime, community development and social inclusion (NIMHE, 2005). These groups and the public in general constitute a vast and as yet untapped resource pool and ally in mental health promotion and mental illness prevention efforts. VicHealth and Scotland in particular have succeeded in actively



engaging these groups in action to promote mental health by finding champions and working toward common goals. Can Canada follow suit?

**Ample evidence exists for the effectiveness of MHP & MIP.** Ample evidence exists for a wide range of MHP & MIP programs and policies, demonstrating that they are an effective public health approach that reaches across the lifespan and across the multiple settings where people live, work, love and play (Jané-Llopis, 2006; WHO, 2004a). Many rigorous reviews of “what works” have been conducted, including interventions to promote mental and physical health in infancy and childhood, efficacious parenting programs, mental health-promoting pre-school and school health programs, workplace interventions, economic and social empowerment of women, community development, violence-prevention programs, interventions for people who are unemployed, and social supports and community services for retired people (Jané-Llopis, 2006; WHO, 2004a). The British Columbia Ministry of Health has released an evidence review of MHP (BC Ministry of Health, 2007).

Many effective interventions are available – the challenge is to determine the priorities for action given the current and anticipated future situation in Canada.

### *Engaging Key Stakeholders – The Art of Connecting*

*“In order to recruit the cross-sector engagement required, synergies across sectors need to be located and a common language developed, which has a focus on health as opposed to illness.”*  
(WHO 2004a: 24)

The challenge of fostering broad and meaningful public and intersectoral collaboration may be addressed in part through what Friedli (2005) calls “the art of connecting” – engaging with other sectors and the public at large toward an understanding of mental health and mental illness and their determinants (Friedli, 2005; Herrman, 2001). The “art of connecting” is a key strategy to engage stakeholders and the public in dialogue and action to understand and promote mental health and also to develop policy. This needs to focus on three areas:

- **Public debate and engagement of what harms and hinders mental well-being**, and building public demand for the protection and promotion of mental health, much like the demand that has been achieved for smoke-free public places. As Friedli (2005: 3) notes,

“Greater public awareness and understanding of mental health as a resource to be protected and promoted could contribute significantly to reducing structural barriers... Perhaps we should focus on building the same demand for mental health and well-being as has been achieved for smoke-free public places.”

A well-informed, engaged public is a powerful tool in advocacy for policies and practices that will promote mental health via action on its social and economic determinants.

- **Policy and emerging ideas.** Similarly, alliances need to be formed with colleagues whose interests are parallel to MHP & MIP. Friedli suggests, for example, alliances with groups who are advocating for the economics of well-being. According to Friedli, this area of inquiry has acquired robust evidence that the structure and quality of social relations are a foundation of well-being. The work of these groups provides a context for analyzing how the drivers of economic growth are undermining social cohesion. Other potential allies are those that emphasize health assets, resilience and strengths, rather than deficits and vulnerabilities.



- **The values underpinning MHP practice.** How we frame issues shapes how the population views and understands them. When mental health is framed in terms of problems and medical issues, people also view them as medical problems and seek medical help rather than reflecting on the social, economic and environmental determinants of mental health and illness. As Friedli (2005: 4) notes,

“The data used to support our case for the importance of mental health...reinforce the myth that mental health problems are a random misfortune, as opposed to a consequence of risk factors that are well understood and strongly associated with social and material deprivation.”

She concludes:

“There is overwhelming evidence that inequality – a key indicator of injustice – erodes mental well-being and that this is one of the key pathways through which deprivation impacts on overall health... Public mental health needs resources and strategic influence, but it also needs a grassroots movement, one which mobilizes against global and local trends that are toxic to the mental health and well-being of all of us” (Friedli, 2005: 5).

**Issues of framing, language and common understanding of mental health.** Friedli’s (2005) point above about framing is worth reiterating here. The language that we use will enable some lines of action and constrain others. Careful attention to how “mental health” is framed is key to engaging diverse sectors and interests. Framing mental health in medical terms, as Friedli has noted, “medicalizes” the term and situates it firmly within the realm (and responsibility) of the medical system rather than as something that is “everybody’s business.” On the other hand, if mental health is construed in broader, humanistic terms – as a part of everyday life – then it becomes relevant to many other groups, and the possibilities for action multiply exponentially.

The issue of framing then leads to issues of language around “mental health.” A common complaint in the literature and in the review of jurisdictions is the lack of consensus on the terms “mental health” and “mental health promotion” within and beyond the field. But there is a difference between consensus on a definition and a shared understanding of concepts and processes. Our key informants pointed out that it is more generative to be flexible in the use of language than to force consensus about what “mental health” means. “The issue of language should never be closed down, because that means that someone’s definition is more important” (Henderson, personal communication, July 2008). People in different fields but with parallel interests may call it something quite different. Indeed, even within the review, a variety of terms were found, including “social and emotional well-being,” “mental healthiness,” “empowerment,” “flourishing,” “resilience,” and “vitality.” For example, the consultation process in EU has revealed how “wellness” appeals to the corporate sector, along with the articulation of how positive mental health reduces absenteeism and increases productivity (Jané-Llopis, personal communication, June 2008). Issues of early school leaving and bullying capture the interest of educators.

Similarly, opportunities for leverage can come from reviewing school curricula then engaging in conversations with educators about issues of mutual importance (Henderson, personal communication, July 2008). The provision of small amounts of resources that enable people, in their own sectors, to create their own solutions can provide further leverage. Importantly, the approach taken in Scotland was not one of “we know how to do this in your sector,” but rather, “we think these things are important and we think your sector is telling us that too” (Henderson, personal communication, July 2008). The art of connecting, then, involves engaging others in dialogue about their interests and priorities – on their terms and in their



language – and about how their interests intersect with those of MHP & MIP. In this way a shared understanding of mutually beneficial goals and actions can be achieved.

**Other levers for engaging a broad coalition of stakeholders.** There is a need to creatively seek other levers to involve people beyond governments and agencies and build a wider coalition of people to communicate a more comprehensive vision that is compelling for all (Henderson, personal communication, July 2008). One such vehicle is the creation of a mental health promotion charter like the one being developed in New Zealand. Its audience is “groups and communities to use as an empowering statement that legitimizes and guides their own action for their own well-being, and for agencies and policy-makers who are prepared to work with this approach” (New Zealand Mental Health Promotion Advisory Group, 2008: 1). Charters, such as the *Ottawa Charter for Health Promotion* (WHO, 1986), can have compelling and sustained impact on perceptions and understanding of issues. They also provide a framework for action on those issues.

The new *European Pact for Mental Health and Well-being* is another lever for engaging a broad coalition. The Pact outlines a shared vision for mental health and defines shared priorities for the European community.

The bottom line is that a wide range of sectors play an important role in promoting mental well-being, and so it is essential that MHP & MIP advocates find ways to talk about positive mental health and what contributes to it in culturally appropriate ways that are meaningful to the public, policy-makers, and other sectors.

### *Visionary Leadership and Fostering Political Will for MHP & MIP*

The World Health Organization (2004a) has observed that government activities typically occur in systems that have little involvement with each other. Effective MHP & MIP at the population level, however, requires integrating mechanisms across these “silos.” This requires a long-term approach with ongoing planning, investments and integration efforts. The WHO notes that progress will be slow, but long-term gains are not always attractive to government. Effective ways of managing political and community discourse are required so that promoting mental health is recognized as a “non-party political public good” (Victorian Health Promotion Foundation, 2005a: 22). This requires skillful and visionary leadership.

All of the key informants interviewed for this paper are international champions of MHP & MIP. They described their own persistent efforts to get MHP on the agenda. Their insights, combined, point to the crucial importance of committed, credible, knowledgeable, politically savvy champions for successful MHP & MIP policy development and implementation.

These leaders of MHP & MIP talked about the power of visionary leadership in government. Some have suggested that Canada’s exemplary health promotion efforts in the 1980s were due in large part to the visionary and powerful leadership of people like Ron Draper, who was able to set out a vision that was revolutionary and to sustain and resource it over a number of years (Raeburn, personal communication, June 2008). The need to develop a strategic approach to politicians who are at first less visionary than people like Ron Draper is also crucially important (Raeburn, personal communication, June 2008). Many of our key informants spoke to the importance of developing good relationships with politicians and of ongoing advocacy efforts.

Advocacy efforts to “manage the political discourse” described by key informants included discussions about the burden of mental illness, the fact that treatment won’t resolve the issue and the power of



positive mental health and MHP & MIP. All stressed the use of economic arguments – particularly the costs of mental illness, the cost effectiveness of MHP & MIP and the fact that mental illness is increasing in prevalence and illness treatment will not stem the rising tide. These approaches, however, need to be considered in light of Friedli’s (2005) argument that the use of medical or illness-oriented discourse risks medicalization of mental health and perceptions that solutions are the mandate of the health sector alone. A good lever for action has been to highlight the work of the WHO and international action in MHP & MIP, and to point out the vast amount of evidence that exists in the field (Barry, personal communication, June 2008). The provision of concrete examples of best practices and their benefits in other jurisdictions was an associated and effective strategy as highlighted in Ireland’s MHP/MIP efforts. Additional arguments noted by key informants to have been persuasive include:

- Emphasizing shared goals with public health and health promotion, asserting that mental health is inseparable from physical health, and, further, that they share the same determinants, which require the same actions – thus mental health is a public health matter.
- Highlighting the benefits of MHP & MIP for other ministries/sectors.
- Targeting social values such as inclusion, equity, liveable and healthy communities, healthy child development, quality of life and so on.
- Focusing on one or a few priority areas, as EU has recently done in the *European Pact for Mental Health*.

## RECOMMENDATIONS

1. MHP & MIP policy development and implementation processes should be congruent with the principles and practices of mental health promotion. This means that a wide spectrum of stakeholders, including the general public, should be engaged in MHP & MIP policy development and implementation in Canada. This will require visionary leadership and mastery of the “art of connecting.”
2. A shared understanding of positive mental health across sectors and the various sectors of society is a crucial platform for successful collaborative action. Achieving a shared understanding will require ongoing efforts to engage the diverse array of stakeholders in ways that are culturally appropriate and meaningful.

## QUESTIONS FOR FURTHER CONSIDERATION

1. Who, specifically, needs to be engaged in the processes of developing and implementing MHP & MIP policies and plans?
2. What is the most effective way to engage these individuals, groups, communities, organizations and sectors?
3. Who will lead these processes of engagement?



## **POLICY DESIGN**

MHP & MIP policy can take several different forms. The focus herein is on whether MHP & MIP policy is integrated into broader mental health policy or whether it is a “stand-alone” policy. In addition, the location of the policy is of interest – does it reside in the mental health services sector or public health? Or is it subtly embedded in broader social policy that emphasizes actions on the determinants of physical and mental health?

## **ANALYSIS OF JURISDICTIONS: POLICY MODELS AND DRIVERS OF MENTAL HEALTH POLICY**

The review surfaced the crucial importance of the political and social context in shaping the nature of mental health and MHP & MIP policies. In England, Scotland, Ireland and Sweden, health inequalities and health determinants, and how positive mental health fits within this broader agenda, are highlighted as policy priorities. These governments typically adopt a “whole-of-government”<sup>7</sup> approach to addressing inequities, health determinants and mental health. While the health sector plays a leading role in promoting mental health, all other government departments are required to integrate health and mental health into their policies. (Interestingly, a recent evaluation of Scotland’s national program concluded that the fact the program is located within the health sector may pose problems in terms of mainstreaming MHP into other sectors (NHS Health Scotland, 2008).) These nations demonstrate how mental health–promoting policy can be integrated into broader social policy, and how action on determinants of mental health occurs through this policy lever. As members of the European Union, these nations also enjoy the support of the EU’s commitment to mental health promotion, including its resources (e.g., policy development, research, and training).

Given this political environment, it is not surprising that the drivers of mental health policy in these nations were concerns about health inequalities. In Scotland and Ireland, concerns about high numbers of suicides, particularly among young men, were compelling factors for policy development. The orientation toward health inequalities facilitated understanding that narrow prevention efforts would be insufficient, and rather that broader, social determinants–based approaches were required for sustained action and effectiveness.

The political climate and systems in Australia and New Zealand are more resonant with those of Canada. The Australian government does employ a whole-of-government approach in some situations, but this was not obvious in the documentation reviewed for this paper. In these jurisdictions, mental health policy stands on its own and is contained within the health system, although there are linkages to policies in other sectors in the mental health policies and plans. Consistent with this, the initial drivers of policy development were concerns about deinstitutionalization of mental health care and the inability of services to meet the needs generated by the shift to community-based services. Significantly, in both nations, specific policies for MHP & MIP were ultimately developed in order to strengthen promotion and prevention activities. In Australia, a stated desire has been integration of MHP policy into public health policy, but this has not yet transpired.

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<sup>7</sup> A “whole-of-government” approach is one in which public service agencies work across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. These approaches may be formal or informal and can focus on policy development, program management and service delivery (Australian Government, 2004).



Various policy models have been adopted across the jurisdictions. These are presented in the table below.

<b>MENTAL HEALTH POLICY MODELS ADOPTED BY VARIOUS JURISDICTIONS</b>	
<b>Australia</b>	MHP & MIP integrated into a broader mental health (MH) policy with subsequent development of an MHP & MIP-specific action plan; located in the health sector
<b>VicHealth (Australia)</b>	A stand-alone plan specifically for MHP; located in organization at arm’s length from government
<b>New Zealand</b>	MHP & MIP integrated into a broader MH policy; an MHP & MIP-specific policy was developed but has not been implemented; located in the health sector
<b>European Union</b>	MHP & MIP-specific policy intended to influence actions of member states; located in European Commission
<b>England</b>	MHP & MIP integrated into a broader MH policy with subsequent development of an MHP & MIP guidance document; located in health sector; intention to “mainstream” MHP & MIP into public health
<b>Ireland</b>	MHP & MIP integrated into broad MH policy in the health sector
<b>Scotland</b>	A stand-alone plan specifically for MHP & MIP; located in the health sector

### **DISCUSSION: WHICH POLICY MODEL IS BEST FOR EFFECTIVE MHP & MIP IN CANADA?**

The fundamental challenges that policy design addresses are maintaining the focus of efforts on a positive and social view of mental health and recovery/rehabilitation, and overcoming pressures to revert to a medical model of illness treatment and service delivery. Political and social contexts play a central role in determining which models are most likely to be effective in this regard. The intent here is not to present a comprehensive review of various policy models and actions; rather, it is to signal the importance of further exploring and carefully considering the merits of various options as Canada moves forward in developing MHP & MIP policy.

As alluded to above, there appear to be at least three policy models amenable to MHP & MIP. These include:

- Incorporation of MHP & MIP into broader mental health policies within the health sector
- Integration of MHP & MIP into public health policy
- Integration of MHP & MIP into broader social policies

**Incorporation of MHP & MIP into broader mental health policies within the health sector.** These policies, such as those of Australia, New Zealand, Ireland, and England, cover the spectrum of mental health approaches – promotion, illness prevention and treatment.



One important advantage of this model is that MHP & MIP can be integrated across the spectrum of mental health efforts, including treatment and recovery.

There are, however, some potential disadvantages:

- There may be a tendency toward greater emphasis on mental illness and treatment services.
- The distinct philosophical base of MHP & MIP – that of a positive view of mental health, participatory and empowerment-oriented approaches, building on strengths, and collaborative actions on the determinants of mental health – is distinct from the medical model upon which mental illness treatment and services have historically been based. Thus there is a risk that the medical model may take precedence over the socio-environmental approach embraced by MHP & MIP.
- Location of MHP & MIP policy within the health sector may lead other sectors to believe that MHP & MIP is a “health” problem, and that the “solutions” to improving health lie only within the health sector. This “silo-effect” may be counterproductive to the collaborative, multi-sectoral approaches required for MHP & MIP.
- Location of MHP & MIP within a broad mental health policy may impede efforts to implement a public health approach to MHP & MIP.

Given these disadvantages, should there be a stand alone policy for MHP & MIP? Key informants had various opinions about this. Some argued that including MHP within the context of service delivery can be the “kiss of death,” because services are oriented to the medical model rather than to a model focused on participatory and empowerment-oriented approaches with individuals, families and communities (Raeburn, personal communication, June 2008). The dominant medical model has difficulty dealing with these approaches. And there is an inherent danger that MHP & MIP will get lost in the urgent demands for treatment and service delivery.

Others noted that inclusion of MHP in general mental health policies is an important supplement to a broader government endorsement of a population approach to mental health promotion (Herrman, personal communication, June 2008). In Ireland, a broad mental health policy has been developed and MHP has been integrated throughout the policy thanks to the advocacy efforts of MHP experts. However, these experts continue to advocate for a separate MHP policy to augment this approach (Barry, personal communication, June 2008).

The ideal, in this policy model, appears to be development of an MHP-specific policy or plan which embraces MHP’s unique philosophy and approach *and* inclusion of MHP & MIP in broad mental health policies and plans.

**Integration of MHP & MIP policy into public health policy.** MHP experts widely advocate for integration of MHP & MIP into public health. Mental health and mental illness are, like physical health, determined by multiple interrelated factors, such as education, employment, housing, poverty, social exclusion and discrimination. This linkage to the social determinants of health is a fundamental concept of public health practice, yet mental health is viewed as being outside the domain of public health (WHO, 2004a). When MHP & MIP remain isolated from public health and health promotion, opportunities for concerted action to improve mental and physical health are lost (Solin, 2004; WHO, 2004a). In addition, efforts to reduce the burden of mental illness wind up depending on treatment of illness instead of proactive approaches to prevent illness from occurring in the first place (WHO, 2004a), and thus the burden of mental illness is likely to grow (Sturgeon, 2007). The WHO (2004a: 49) concludes:



“The twin aims of improving mental health and lowering the personal and social costs of mental ill-health can only be achieved through a public health approach... Within a public health framework, the activities that can improve health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected. These are different from one another, even though the actions and outcomes overlap. They are all required, are complementary, and one is no substitute for the other.”

Similarly, a key informant noted,

“If we keep having those discussions about [MHP & MIP] whilst we’re still trying to satisfy the needs and demands of a mental illness system, we’re still going to be pulled down into business as usual. It means that policy-makers in that arena are permanently firefighting the illness agenda. They don’t have the space or the time, and they also don’t have the links into the wider world of physical health, of nutrition, of sexual health, of alcohol, of drug addiction. They’ve got to get way upstream and into these other arenas. And you are more able to do that from a public health and well-being point of view if you’re having that discussion as a public health approach with your education colleagues, with your employment colleagues, with your culture and art colleagues, because you’re coming from a position of promoting, maintaining and improving wellness and health, not responding solely to illness – though having this promotive approach also helps in addressing illness and the consequences of illness.”  
(Henderson, personal communication, July 2008)

**Integration of MHP & MIP policy into broader social policies.** In this model, MHP & MIP are part of a broader social policy located beyond the health sector. An example is Sweden’s determinants of health-based policy. This is the model that the World Health Organization (2005a: 49) endorses as most powerful because it offers more opportunities to engage a broad array of sectors in actions to promote mental health:

“If mental health policy is developed as part of a broader social policy (rather than as a stand-alone policy or subsumed within a general health policy) the emphasis on mental health promotion is likely to be more substantial. There are more opportunities to engage a variety of stakeholders representing different sectors in the development and implementation of the policy.”

Each model inevitably has strengths and weaknesses; some preliminary thoughts about these are presented in the table below.



<b>STRENGTHS AND LIMITATIONS OF MHP &amp; MIP POLICY OPTIONS</b>		
<b>MODEL</b>	<b>STRENGTHS</b>	<b>LIMITATIONS</b>
<b>MHP &amp; MIP integrated into broad MH policy situated in the general health sector</b>	Enables a seamless approach – integration of MHP & MIP across all dimensions of MH services	Risks sublimation of MHP & MIP to seemingly more urgent demands for treatment and services and medical model– approach  May impede intersectoral collaboration on determinants of MH
<b>Distinct MHP &amp; MIP policy situated in the general health sector</b>	Enables focus on MHP & MIP	Without strong linkages to other sectors and policies, may contribute to the “silo effect”  Risks insufficient resourcing if not a priority in the sector (e.g., New Zealand)
<b>MHP &amp; MIP policy situated within public health</b>	Strong potential for synergistic action with general health promotion and public health activities, including <ul style="list-style-type: none"> <li>▪ Action on health determinants</li> <li>▪ Skill and existing connections re. intersectoral collaboration</li> <li>▪ Ability to draw on public health capacity and expertise in health promotion</li> <li>▪ Funding doesn’t compete with mental health treatment and services</li> </ul>	May impede integration of MHP & MIP into the mental health treatment system
<b>MHP &amp; MIP incorporated into broad social policy</b>	More likely that determinants of MH will be addressed	Potential loss of focus specifically on mental health  May suffer against competing priorities  Difficult to measure MHP & MIP outcomes



## **RECOMMENDATION**

Further exploration of the merits of various policy models for MHP & MIP policy in Canada should be conducted. Emphasis should be placed on a model that:

- enables enactment of the fundamental principles and processes of MHP & MIP – i.e., a positive conceptualization of mental health; participatory, empowerment-oriented approaches; approaches that build on strengths and assets; and collaborative, multi-sectoral action on the structural determinants of mental health;
- enables integration of MHP & MIP into mental illness treatment and services; and,
- ensures a sustained emphasis on MHP & MIP actions.

## **QUESTIONS FOR FURTHER CONSIDERATION**

1. How can MHP & MIP policy be designed such that it:
  - enables enactment of the fundamental principles of MHP & MIP?
  - enables integration of MHP & MIP into mental illness treatment and services?
  - ensures a sustained emphasis on MHP & MIP actions?
  
2. How might cross-sectoral action for MHP & MIP be facilitated through policy design?



## **POLICY CONTENT AND FOCUS**

Mental health policies provide overall direction for MHP & MIP activities. They typically contain:

- A vision statement that sets out what is expected to be achieved some years after implementation of the policy;
- Values and principles – statements about what is considered desirable (values) and standards to guide actions (principles);
- Objectives – measurable goals that break the vision down into achievable tasks;
- Areas for action and strategies that will take help achieve the objectives; and,
- A model for planning and evaluation (WHO, 2005a).

The importance of collaborative action in developing MHP & MIP has been articulated above; it is therefore assumed in this section that such collaboration is a central vehicle for determining the content and focus of MHP & MIP policy.

## **ANALYSIS OF JURISDICTIONS: MHP & MIP CONTENT**

MHP & MIP policies and plans reviewed for this document typically included the following components:

- Definitions of terms
- Rationale for MHP & MIP
- The jurisdiction's approach to MHP & MIP
- Goals and objectives
- A model or framework of MHP & MIP
- Statement of priorities for action: settings, population groups and specific actions

Key goals and objectives and areas for action are presented in the table below.



<b>CONTENT/FOCUS OF MH POLICY IN OTHER JURISDICTIONS</b>	
<b>JURISDICTION</b>	<b>CONTENT/FOCUS</b>
<b>Australia</b>	MHP MIP early intervention for multiple segments of society
<b>Australia (VicHealth)</b>	MHP Strong orientation to building capacity and evidence base for MHP Increasing community understanding of the determinants of MH
<b>New Zealand</b>	Increasing awareness of MH Inclusion and support for mental illness Anti-discrimination Suicide prevention Early interventions and prevention of addictions
<b>European Union</b>	Workplace Youth and education Older people Suicide prevention Stigma and exclusion
<b>England</b>	Making it Possible provides “good practice” to support development and delivery of MHP actions for multiple groups
<b>Ireland</b>	Promoting positive MH Raising awareness of the importance of MH Enhancing capacity of MH service providers and general community to promote positive MH Suicide prevention
<b>Scotland</b>	MHP Mitigation of stigma and discrimination Suicide prevention Promoting recovery



Some themes arising from the analysis of jurisdictions are presented below.

**Awareness.** Many MHP & MIP policies and/or action plans incorporated a focus on creating public awareness of mental health and mental illness. This often took the form of anti-stigma and anti-discrimination campaigns, some of which have been very successful, most notably the Like Minds Like Mine campaigns in New Zealand, which have received international recognition.

**Incorporation of MHP & MIP principles.** An interesting observation is that while all MHP & MIP action plans conceived mental health in positive terms and advocated for collaborative action on health determinants, none of the policies or action plans placed a strong emphasis on empowerment-oriented approaches and building upon existing strengths and assets, traditional hallmarks of MHP. This may be due to the high-level nature of the policies; perhaps these principles come into play when specific actions and programs are implemented on the ground. However, it does seem important that, given the philosophical base of MHP in particular, these principles should be manifested in some way in the focus of MHP policies and plans.

**MHP & MIP specific action plans – stronger focus on positive mental health at the population level.** Most MHP & MIP-specific action plans emphasized the promotion of positive mental health and well-being for the population and improvements in the breadth and effectiveness of population strategies to promote mental health and prevent illness. These plans were more likely to address issues such as inequalities related to mental health.

**Building capacity for MHP & MIP.** Plans in VicHealth, England and Scotland included efforts to build workforce capacity for MHP & MIP.

**Targets for action.** MHP & MIP plans typically identify the entire population and various subgroups as targets of action; some, such as VicHealth, prioritize particular groups. A wide range of actions is outlined in the plans. The Australian plan sets out desired outcomes for each population group, rather than delineating specific actions. For example, for the group “Young People 12–17 Years,” desired outcomes include environments and infrastructure that support family and social functioning, school environments that enhance mental health and mental health literacy, opportunities for personal development and exploration, positive peer relationships and many others.

Action plans typically include detailed descriptions of actions, including population groups, desired outcomes, rationale and evidence base for action, roles and responsibilities, and linked initiatives, and, in the case of Australia, research questions.



## **DISCUSSION: WHAT ARE THE KEY ELEMENTS TO BE INCLUDED IN AN MHP & MIP POLICY FOR CANADA?**

Several considerations need to be taken when determining the content and focus of the policy. These include:

- How can the vision, values, goals/objectives and action plans be grounded in the key principles and strategies of MHP & MIP, including the need for collaborative action across the lifespan and across population groups, sectors, settings and policy levels?
- What are the most pressing issues to be addressed? How shall these be determined?
- What is already known in terms of effective practices and programs in MHP & MIP – that is, what are the best practices for promoting mental health and preventing mental illness?
- What are the existing strengths and assets for MHP & MIP – what programs and policies are already in place? To what extent are they effective? What are the gaps?
- What will be the mechanisms for implementation, accountability (clear roles and responsibilities) and funding (Barry & Jenkins, 2007)?
- How do actions outlined in the policy link to other relevant policies and programs, including those in other sectors?

**Grounding policy in MHP & MIP principles and strategies.** The litmus test for MHP & MIP policy should be checking the vision, goals/objectives and actions against the key principles and strategies of MHP & MIP. For example: Is the policy grounded in a positive conceptualization of mental health? Does it address the determinants of mental health and risk and protective factors? Does it embrace participatory and empowerment-oriented processes? Does it include a range of actions across the lifespan in different populations, settings, sectors and policy levels?

**Determining the most important issues to be addressed.** Policy-makers need to think carefully about how the vision, principles, goals and priorities for MHP & MIP policy will be determined. Many factors need to be considered and only a handful are discussed herein. One important consideration is the need to adopt a public health approach that moves beyond a focus on individuals to the health of communities and populations, and actions on the determinants of mental health.

Many, if not all jurisdictions began with a focus on raising awareness – often in terms of stigma and discrimination. However, while crucially important, a focus on stigma and discrimination associated with mental illness is distinct from awareness related to positive mental health. This is a factor that Canadian policy-makers need to seriously consider, particularly in light of the discussion earlier in this document regarding conversations that are likely to bring key stakeholders on board. A positive conceptualization of mental health makes MHP efforts relevant to all people in all sectors. Thus awareness components of MHP & MIP policy need to embrace both anti-stigma and anti-discrimination efforts and efforts to promote broad public awareness of the importance of positive mental health.

Another consideration is the changing demographic profile of Canada – particularly its growing cultural diversity and its growing First Nations population. Aging of the baby boomer generation will also have an



important impact on mental health issues. At the other end of the spectrum, MHP & MIP with children and youth may reap significant benefits which extend well into the future.

It may be prudent to select only a handful of priorities – two or three – to begin with (Lahtinen, personal communication, June 2008).

**Building on what is known while customizing to the local context.** In determining the content and focus of MHP & MIP policy, it is “crucial to build on what is already known, but also to balance best international practice with creative local practice and capacity at the local level for implementation” (Barry, personal communication, June 2008). In Canada’s favour is the fact that many good resources for determining “evidence-based” practice are available. Some of these include Australia’s *Promotion, Prevention and Early Intervention for Mental Health* (Commonwealth Department of Health and Aged Care, 2000a), VicHealth’s *Evidence-Based Mental Health Promotion Resource* (Keleher & Armstrong, 2006) and British Columbia’s recently released evidence review of MHP (BC Ministry of Health, 2007). Web-based resources such as those produced by national and international networks: Auseinet and IMHPA (Implementing Mental Health Promotion Action) are also available.

**Identifying existing policies and programs relevant to MHP & MIP.** Determination of policy content will also depend on an understanding of the policies and programs that are already in existence – that is, determining what other sectors and organizations are doing such that opportunities for synergy can be seized and overlaps and duplications can be avoided. For example, several Canadian provinces have extensive early childhood intervention programs that run through ministries of education or social services or children’s services – these may be MHP strategies masked by different language. At the national or even provincial/territorial level, this can be an extensive process. How can this be achieved?

Many other sectors and organizations are doing exemplary work that can be classified as MHP & MIP. As described earlier, attention to how “mental health” is framed, and attention to the language that is used in conversations with others can make a significant difference in engaging other sectors and also in assessing the extent to which effective action is already being taken in other sectors.

In addition, policy analyses are being conducted regarding population health policy in Canada (Keon & Pepin, 2008). This work, hosted by the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology, is exploring options for tracking health outcomes, reorienting government policy, implementing an Aboriginal Population Health Strategy and fostering political will. This work presents one of hundreds of potential opportunities for synergistic action to promote the physical and mental health and well-being of Canadians. It is oriented toward actions on health determinants and resolution of health inequalities.

**Determining mechanisms for implementation, accountability and resourcing.** This is discussed in detail in the section below, but plans for implementation need to be made in concert with policy development. Given the challenges experienced by other jurisdictions in implementation, this is crucial.

**Linking MHP & MIP policy to other relevant policies and programs.** Once the policy content is determined, the linkages between it and other relevant policies should be made explicit. This will help to avoid confusion, overlaps and duplications that other jurisdictions have experienced.



## **RECOMMENDATIONS**

1. A shared vision for positive mental health, MHP & MIP in Canada is needed to build momentum and generate energy for action.
2. MHP & MIP policy content should be informed by a review and analysis of existing policies and programs in mental health, health and other sectors.
3. The selection of two or three priority areas would help to focus initial efforts.

## **QUESTIONS FOR FURTHER CONSIDERATION**

1. Who will lead policy development and determination of policy content?
2. How will policy content and focus be determined?



## **POLICY IMPLEMENTATION**

*“There is incredible energy generated in developing a new policy; the key to successful implementation is to sustain that level of energy during the implementation process.”*  
(Barry, personal communication, June 2008)

Many key informants noted that an eloquent and well-developed MHP & MIP policy does not ensure effective implementation on the ground. This is strongly supported in the literature. A supportive policy environment is critical to ensure sustained and effective action to promote positive mental health. This includes dedicated resources; an infrastructure that includes research, training and development; and strategic leadership to drive the MHP & MIP agenda forward (Barry & Jenkins, 2007).

Barry and Jenkins (2007: 34) outline the process of developing such an infrastructure for MHP:

- Establish a policy framework that provides a mandate for action.
- Develop a strategic action plan which identifies priorities, key goals and objectives for action.
- Coordinate an intersectoral and partnership approach to policy implementation at governmental, regional and local levels.
- Invest in research to guide evidence-based MHP policy and practice.
- Invest in human, technical, financial and organizational resources to achieve priority actions and outcomes.
- Support capacity building and training of the mental health promotion workforce to ensure effective practice and program delivery.
- Identify models of best practice and support the adoption and adaptation of high quality, effective and sustainable programs, particularly those meeting the needs of disadvantaged groups.
- Engage the participation of the wider community.
- Put in place a system to monitor policy implementation and impact.
- Systematically evaluate program process, impact, outcome, and cost.

## **ANALYSIS OF JURISDICTIONS: IMPLEMENTING MHP & MIP POLICY**

### *Successes experienced by other jurisdictions*

Mental health and MHP & MIP policy has significantly advanced efforts in all jurisdictions. This has been evidenced by shifts in government understanding of and commitment to positive mental health, MHP & MIP, acceleration of the change process, multi-sectoral collaboration to promote mental health and ownership of MHP & MIP by other sectors, enhanced capacity for MHP & MIP and, most importantly, action and results “on the ground.”



Each jurisdiction has different structures for oversight of MHP & MIP policy implementation. In Australia, a new body was created specifically to oversee implementation of the MHP-specific action plan. Similarly, a national team was created to lead policy implementation in Scotland. This team adopted a specific change-management process to aid its efforts. In England, mental health offices are located in each health region to support implementation. In New Zealand, district health boards are responsible for implementation. In the European Union, each member state is responsible for implementation. VicHealth, which is primarily a grantor, helps other organizations to implement various initiatives.

### *Challenges encountered by other jurisdictions*

Despite these successes, in almost every jurisdiction reviewed, implementation of mental health policy was described as a key challenge. While MHP & MIP policy is eloquently articulated in many national policies, this does not necessarily translate into action on the ground. This was particularly noted in New Zealand (Ball, 2006). Evaluations of mental health policies and plans in Australia revealed clear and appropriate direction in policy and plans at the national level, but variable commitment to execution at the state and territorial levels. Similarly, it was noted that in the EU, many nations espouse MHP & MIP in their policies, but this is not always followed up in actual practice (Jané-Llopis, personal communication, June 2008). Some of the associated challenges are described below.

**Lack of ongoing leadership to fuel the implementation process.** The need for ongoing leadership to energize and support ongoing implementation of policies and plans was consistently identified in evaluations of MH policy in the jurisdictions reviewed for this document. Leadership functions included “championing the cause,” oversight and evaluation of the implementation process, coordination of efforts with other sectors and organizations in related activities, training and development, research and knowledge translation, and monitoring and evaluating MHP & MIP efforts. Various approaches were adopted by each jurisdiction for this purpose; some were more successful than others, but an in-depth analysis would be required to make a responsible assessment of the reasons for this. In Australia, implementation, evaluation and monitoring of the MHP & MIP plan is the responsibility of the National Public Health Partnership Group. In the state of Victoria, VicHealth, as a stand-alone organization at arm’s length from government, emphasizes research, training and development. As an independent body responsible for MHP, leadership is inherent in its mandate and structure. In Scotland, a National Advisory Committee initially took leadership for implementation, but over time became less active; evaluation of the program revealed the need to replace the Committee with a strong guiding coalition to continue to fuel the implementation process.

**Insufficient resources for MHP & MIP.** In almost every jurisdiction, mental health strategies had yielded additional funding for mental health, yet these funds were inadequate to meet the demand for service. It was noted that in New Zealand, funding for MHP & MIP was “minuscule” and thus efforts were only “scratching the surface” (Ball, 2006). A notable exception is the case of Scotland, which received special funding for public health when it assumed independence for health service delivery; as these funds came from public health, they were not perceived to compete with mental health services and treatment. This was a significant factor in building good relationships with the service and treatment dimension of mental health. Interestingly, Chile – a developing nation with few resources – has been able to take action via collaboration with other sectors, particularly education (Minoletti, personal communication, June 2008).

**MHP & MIP not integrated into public health.** Despite the relevance of mental health to the public health agenda and national interests in placing mental health within the public health sphere, this has proven difficult in practice. Scotland and Australia have made concerted efforts in this regard, without success. In other jurisdictions, there were some suggestions that key people who could make this happen



didn't "get it" – that is, they didn't understand the linkages between mental health, physical health and public health.

**Difficulties in engaging other sectors in MHP & MIP actions.** All jurisdictions reported use of consultative and in some cases participatory approaches to engaging other sectors, yet evaluations consistently surfaced the challenges of doing so on an ongoing basis, again related to issues around lack of leadership and/or resources.

**Confusion of roles between MHP, MIP and service delivery.** Specifically, there is confusion about who is responsible for MHP & MIP. This was the case particularly when MHP & MIP were integrated into broad strategies that include services and treatment. It was not always clear "on the ground" how MHP & MIP fit within these approaches, and "who was responsible for what" Compounding this is the fact that service models and training of workers are typically oriented toward the medical model, with little or no training in MHP/MIP.

**Lack of coordination of multiple policies and plans at multiple levels.** Coordinating actions at multiple levels and across sectors has been difficult in all jurisdictions. There is often confusion about how various action plans fit together and who is responsible for implementation. This leads to unnecessary duplication of effort and resources, and a lack of awareness of similar initiatives undertaken in different strategies. There is a need, thus, for integrating mechanisms through which linkages, roles and responsibilities are made explicit, and where information is easily shared.

## **DISCUSSION: HOW CAN WE SUPPORT EFFECTIVE IMPLEMENTATION AT DIFFERENT LEVELS AND ESTABLISH THE INFRASTRUCTURE AND RESOURCES NEEDED?**

In every jurisdiction reviewed, implementation of policies and plans presented major challenges. These included ensuring sustained leadership and advocacy for MHP & MIP that can drive change across sectors; facilitating cross-sector and cross-government collaboration; ensuring adequate resources, including training and development (within the health sector and beyond), financial resources, information about mental health status, about effective MHP & MIP practices, and about existing policies and programs that support MHP & MIP goals; ensuring coordination of policies, plans and initiatives across sectors; conducting research and evaluation; and monitoring progress.

**An infrastructure to lead, monitor and sustain effective implementation.** The value of a solid infrastructure for implementation of MHP & MIP policy cannot be understated. This would be particularly powerful in Canada, given its size, diversity, and multiple levels of government. A useful model is that of the US Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion. Its key roles include:

- Leadership and advocacy for health promotion and disease prevention;
- Oversight of knowledge transfer and translation;
- Convening and brokering relationships – being a catalyst for partnership with other bodies;
- Developing standards and models of practice;
- Evaluating evidence-based practice and practice-based evidence;
- Monitoring and surveillance; and,
- Funding initiatives through granting processes (Navarro et al., n.d.).



Such a body could also serve as a coordinating “hub” that makes clear how various strategies are linked together and whereby information, knowledge and networks can converge – this would help avoid overlaps, duplications, and enhance the synergy of such initiatives.

Deliberation is required about whether an existing body, such as the Mental Health Commission, might be suitable for leading and overseeing implementation of a national-level MHP & MIP-specific policy. Given that the Mental Health Commission’s current mandate is to “to help bring into being an integrated mental health system that places people living with mental illness at its centre” (Mental Health Commission of Canada, Online; emphasis added), it may not be ideally suited for leadership in MHP & MIP. Given that the determinants of mental health lie outside the health sector, and thus that public health approaches are most suitable for MHP & MIP, it would seem more appropriate that oversight and leadership for MHP & MIP policy development and ongoing implementation should rest in the public health domain either at the national or provincial level. In that case, is a new, independent body required, or are there existing bodies and structures capable of championing MHP & MIP – such as the Public Health Agency of Canada?

Other important aspects of implementation are discussed below.

**A clear, specific, resourced and monitored implementation plan.** Most essential is a detailed implementation plan that clearly outlines roles, responsibilities and accountabilities (Barry, personal communication, June 2008).

**Resources.** “What’s the point of having an action plan if there are no resources for implementation?” (Jané-Llopis, personal communication, June 2008). The accuracy of the remark above is evidenced by the case of New Zealand’s MHP & MIP policy, *Building on Strengths*. Without resources, it stalled. There are several forms of resources to consider in implementing MHP & MIP policies and plans. These are briefly described below.

**Financial resources.** Effective MHP & MIP requires adequate and sustained funding. Several key informants noted it is crucial that perceptions of competition with mental health services and treatment for funding must be avoided. *To the contrary, it needs to be clear that MHP & MIP are complementary to treatment and service delivery because they attenuate the factors contributing to mental illness and strengthen those that facilitate positive mental health.* Further, MHP is consistent with a recovery orientation to treatment. The nature of MHP – specifically, that it adopts a population-wide approach and collaborates with sectors beyond health – needs to be made clear.

**Research and evaluation.** While there is a good evidence base for MHP & MIP, ongoing research is required to enhance the effectiveness of MHP & MIP and to support ongoing policy development. For example, arguments are made for the need to develop a research agenda that explores the social determinants of flourishing (Keyes, personal communication, June 2008). Now that there are valid indicators of positive mental health, it is possible to study the structures that would allow more people to flourish and for longer in their lives. Research is also needed regarding the outcomes of MHP and the impact of actions by other sectors on mental health (Hosman, personal communication, July 2008). There is also need for evidence on upstream policy interventions, the economic benefits of MHP & MIP, and the cost effectiveness of MHP & MIP interventions (Parham 2008).

One of the challenges in MHP & MIP research is the “research paradigm,” how it determines what constitutes “evidence,” and the associated methodologies. Aligned with this is the longitudinal nature of most prevention research, where the outcomes are not realized immediately. Given that the MHP & MIP



field is made up of diverse stakeholders with varying needs, each of the stakeholders will view the evidence from a different perspective. This multiplicity and diversity of need with respect to evidence and its use provides the impetus for bringing together researchers, policy-makers and practitioners to create some innovation and to set an agenda for investing in research that will underpin both policy and practice in the future (Parham 2008: 4).

**Knowledge translation.** Training and practice on the ground require the support of good evidence about “what works” and in what contexts. Ongoing research and translation of research findings into practice is thus a key aspect of successful implementation (and policy development). Canada is fortunate in that an extensive internationally recognized evidence base already exists. Australia has developed at least two seminal documents regarding the evidence base for MHP & MIP (Commonwealth Department of Health and Aged Care, 2000; Keleher & Armstrong, 2006) as has the World Health Organization (2004a; 2004b). The British Columbia Ministry of Health has recently released an evidence review of MHP (BC Ministry of Health, 2007). In addition, the Canadian Best Practices Portal for Health Promotion and Chronic Disease Prevention is currently incorporating information on MHP.

Evidence-based MHP frameworks, such as those developed by VicHealth and Scotland, are available. One particularly valuable resource is that of the Implementing Mental Health Promotion Action (IMHPA) network in Europe, an international network of expert partners from 30 European countries, other international networks and professionals that supports the development and implementation of MHP & MIP across Europe (IMHPA, Online). Examination of this network may be particularly useful in Canada, especially in light of the Mental Health Commission’s commitment to developing a knowledge exchange centre.

**“The right suite of skills on the ground” – A skilled workforce.** Margaret Barry spoke of the crucial importance of building workforce capacity – to get the right suite of skills on the ground. She suggested that mental health specialists could be catalysts to train others and also to drive implementation. The “others” to be trained include the wider social services and public health workforce, including teachers and social workers. In this way, it is possible to develop a group of MHP champions who will mind the implementation process. The World Health Organization (2004: 24) has noted that actions on structural determinants of health require multiple methods, and it can be a challenge to develop workforces that have the necessary conceptual and practice skills. Training specific to MHP & MIP is essential – not just for people in the mental health and health field, but also for those working in other sectors that impact mental health – education, employment, community and NGOs, for example. Auseinet (a network of professionals and experts working in MHP/MIP) in Australia has received international attention for its success in leading and coordinating implementation of MHP & MIP policy, but Parham (2008) has noted it is insufficiently funded for the scope of the task at hand. Also, specific skills development is needed in the areas of strategic leadership, partnership building and networking in order to effectively engage diverse sectors. Moreover, the capacity for translation of policy and evidence into effective and sustainable local implementation is a critical element of workforce development (Parham, 2008).

**Valuing and disseminating lessons learned from practice.** It is equally important to value and disseminate the lessons learned from practice – practice-based knowledge. Venues in which practitioners and research can exchange experiences and knowledge regarding successes and failures “on the ground,” discern promising approaches and further explore new ones are necessary to advance the practice of MHP & MIP. Appropriately hosted and resourced, such venues could be fertile seedbeds for innovation.

**Other resources – creating the context and opportunities to advance MHP & MIP.** Beyond legislation and funding, government can help create the context and opportunities that advance the



development of MHP policy and practice. Government can also provide opportunities for enhancing knowledge and action – such as forums for discussion and debate, improving the “science” and evidence, research, and disseminating and transferring knowledge (Henderson, personal communication, July 2008).

**Monitoring systems.** (See the selection below re. Monitoring and Evaluation).

## **RECOMMENDATION**

Implementation infrastructure will depend on MHP & MIP policy design, but a specific infrastructure specifically for MHP & MIP (or perhaps health promotion in general as well) is highly desirable. Strong leadership is required to champion MHP & MIP and to keep efforts focused on promotion and prevention.

## **QUESTIONS FOR FURTHER CONSIDERATION**

1. Who shall lead implementation of MHP & MIP policy in Canada?
2. How can we most effectively ensure sustained leadership and oversight of MHP & MIP policy implementation?
3. What existing bodies, policies and programs can support MHP & MIP action in Canada? Are new institutions needed to oversee MHP & MIP policy implementation and evaluation? Or is it possible to integrate MHP & MIP policies and plans into existing structures at the national, provincial/territorial and local levels?
4. What resources are required (financial, human, training, research, evaluation)? Are new funding mechanisms needed to secure these resources?
5. How can we facilitate and invest in research to guide MHP & MIP policy and practice?
6. How do we expand the knowledge base for positive mental health in order to effectively translate knowledge into practice?
7. How can we build capacity and train the workforce in public health and other sectors to prepare them to become enablers and advocates for MHP & MIP across sectors?
8. How can we sustain the engagement of key stakeholders in an ongoing, mutually generative and mutually beneficial manner?



## POLICY MONITORING AND EVALUATION

Policy monitoring refers to routine tracking of the plan. Evaluation refers to a “systematic means of appraisal to assess the value, worth or effectiveness of the policy or plan” (WHO, 2005e: 2). To understand whether the policy/plan is meeting its objectives, it is necessary to monitor and evaluate implementation of the policy/plan and to assess whether the objectives of the policy/plan have been met or not (WHO, 2005e).

An important aspect of evaluating outcomes of MHP & MIP policies and plans is measurement. The vast proportion of resources in mental health is aimed at detection and treatment, and much of the surveillance that occurs aims to assess the impact of these activities. As a result, measuring the outcomes of MHP & MIP has little sway in mainstream health surveillance and monitoring (Zubrick & Kovess-Masfety, 2005: 149). Statistics regarding the growing global burden of mental illness galvanized action around the world – and a movement toward MHP & MIP. Evaluation of MHP & MIP requires measures that are responsive to their strategies. Measuring the absence of illness will not suffice. New measures – those that capture changes in positive mental health – are required to evaluate the results of MHP & MIP actions and also to secure ongoing investments in these approaches.

The focus herein is on efforts in other jurisdictions to develop indicator systems of positive mental health and of capacity building.

### ANALYSIS OF JURISDICTIONS: POLICY MONITORING AND EVALUATION

**Monitoring progress along the way.** The National Institute for Mental Health in England (NIMHE, 2005) highlights research-based evidence for the benefits and effectiveness of promoting health in nine areas and provides suggestions for measures of success. These measures are presented in the table below.

<b>PUBLIC MENTAL HEALTH: KEY AREAS AND MEASURES OF SUCCESS (NIMHE, 2005)</b>	
<b>Marketing mental health</b>	<p>People are well informed and motivated to look after their own and others’ mental health</p> <p>People have positive and accepting attitudes to people with mental health problems</p>
<b>Equality and inclusion</b>	<p>People have access to a wide range of sources of support for emotional and psychological difficulties</p> <p>Reduction in inequalities in access to non-pharmacological sources of support</p>
<b>Tackling violence and abuse</b>	<p>Reduction in prevalence of mental health problems</p> <p>Reduction in self-harming behaviour</p>
<b>Parents and early years</b>	<p>Parents and caregivers have the knowledge, skills and capacity to meet the emotional and social needs of infants and young children</p> <p>Parents and carers have access to support for themselves in their parenting roles, delivered to them in a way that is evidence-based and meets their needs</p>
<b>Schools</b>	Schools achieving National Healthy Schools Status targets and delivering SEAL



<b>Employment</b>	Reduction in mental health–related unemployment
<b>Workplace</b>	Workplaces adopt HSE stress-management standards
<b>Communities</b>	Improved quality of life and life satisfaction Increase in proportion of local areas with high “livability” score
<b>Later life</b>	Improved life satisfaction among older people Increased opportunities for older people to participate
Source: NIMHE, 2005: 2	

**Monitoring outcomes.** One barrier to effective and coordinated action in MHP & MIP is lack of consistent indicators of positive mental health.

For Canada, this is both a challenge and an opportunity, since developing a set of indicators at the outset would avoid problems of different measures and measurement systems and different ways of collecting data across the provinces and territories. Several valid indicators of positive mental health (and subjective experience) have been developed primarily in the US and Europe (e.g., Eurobarometer, Energy and Vitality Index).

Keyes (2005; 2002) has developed and tested a set of indicators of flourishing – these are listed in the table below.

<b>KEYES’S (2007A) SIGNS AND SYMPTOMS OF MENTAL WELL-BEING (FLOURISHING)</b>	
<b>DIMENSION</b>	<b>DEFINITION</b>
<b>POSITIVE EMOTIONS (I.E., EMOTIONAL WELL-BEING)</b>	
<b>Positive affect</b>	Regularly cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
<b>Avowed quality of life</b>	Mostly or highly satisfied with life overall or in domains of life
<b>POSITIVE PSYCHOLOGICAL FUNCTIONING (I.E., PSYCHOLOGICAL WELL-BEING)</b>	
<b>Self-acceptance</b>	Holds positive attitudes toward self, acknowledges and is accepting of human differences
<b>Personal growth</b>	Seeks challenge, has insight into own potential, feels a sense of continued development
<b>Purpose in life</b>	Finds own life has a direction and meaning
<b>Environmental mastery</b>	Exercises ability to select, manage and mold personal environs to suit needs



<b>Autonomy</b>	Is guided by own, socially accepted internal standards and values
<b>Positive relations with others</b>	Has or can form warm, trusting personal relationships
<b>POSITIVE SOCIAL FUNCTIONING (I.E., SOCIAL WELL-BEING)</b>	
<b>Social acceptance</b>	Holds positive attitudes toward, acknowledges and is accepting of human differences
<b>Social actualization</b>	Believes people, groups and society have potential and can evolve or grow positively
<b>Social contribution</b>	Sees own daily activities as useful to and valued by society and others
<b>Social coherence</b>	Interested in society and social life and finds them meaningful and somewhat intelligible
<b>Social integration</b>	A sense of belonging to, and comfort and support from, a community
Source: Keyes, 2007a: 98	

After three years of intensive development, Scotland has generated an indicator set for adult mental health. The 55 indicators cover both positive mental health and mental health problems (see the table below). They are structured under two categories: high level constructs of mental health status (outcome measures) and contextual constructs which cover risk and protective factors and the consequences of mental health at individual, community and structural levels (NHS Health Scotland, 2007). A second set of positive mental health indicators for children is in development. As part of these indicator sets, a new *Warwick-Edinburgh Mental Well-Being Scale* has been developed – a 14-item scale that covers hedonic and eudaemonic perspectives of well-being. The scale has been used in two national Scottish surveys to date with good performance.



<b>SCOTLAND'S NATIONAL ADULT MENTAL HEALTH INDICATORS (2007)</b>			
<b>HIGH LEVEL CONSTRUCTS</b>			
Positive mental health [life satisfaction]		Mental health problems [common mental health problems, depression, anxiety, alcohol dependency, drug-related deaths, suicide, deliberate self-harm]	
<b>CONTEXTUAL CONSTRUCTS</b>			
<b>INDIVIDUAL</b>	<b>COMMUNITY</b>	<b>STRUCTURAL/POLICY</b>	
Learning and development (adult learning)	Participation (volunteering, involvement in local community, influencing local decisions)	Equality (income inequality, equality analysis)	
Healthy living (physical activity, healthy eating, alcohol consumption, drug use)	Social networks (social contact)	Social inclusion (worklessness, education)	
General health (self-reported health, long-standing physical condition or disability, limiting long-standing physical condition or disability)	Social support (social support, caring)	Discrimination (e.g. gender/sex discrimination, racial discrimination, harassment)	
Spirituality	Trust (general trust, neighbourhood trust)	Financial security/debt (financial management, financial inclusion)	
Emotional intelligence	Safety (neighbourhood safety, home safety, non-violent neighbourhood crime, perception of local crime)	Physical environment (neighbourhood satisfaction, noise, escape facility, green space, house condition, overcrowding)	
		Working life (stress, work-life balance, demand, control, manager support, colleague support)	
		Violence (partner abuse, neighbourhood violence, attitude to violence)	
Source: NHS Health Scotland, 2007			



## **DISCUSSION: HOW DO WE EVALUATE MHP & MIP POLICY IMPACT TO ENSURE ACCOUNTABILITY FOR MENTAL HEALTH?**

Mental health promotion and mental illness prevention focus on actions and process more than on directly addressing mental health outcomes (Lehtinen et al., 1997, cited in Commonwealth Department of Health and Aged Care, 2000: 22). As such, monitoring and evaluation of progress in MHP & MIP at the population level may not always include mental health or mental ill health outcome measures but rather will focus on changes in risk and protective factors (Commonwealth Department of Health and Aged Care, 2000). A challenge is that the outcomes of MHP & MIP efforts may not be evident until several years after the intervention. For this reason, a variety of processes that occur at different levels, in different contexts and among communities must be assessed (Commonwealth Department of Health and Aged Care, 2000). On the other hand, long-term monitoring of positive mental health outcomes is essential to judge progress over time.

Canada has already laid a foundation for monitoring positive mental health. Statistics Canada's had a specific focus on mental health. It may be possible to build upon the 1994–1995 *Canadian National Population Health Survey* (NPHS) by including measures of 2002 Community Health Survey mastery, happiness, self-esteem, sense of coherence or psychological well-being.

## **RECOMMENDATION**

Canada should develop a set of positive mental health indicators to mark progress in MHP & MIP efforts. The existing capacity of Statistics Canada makes this organization a logical candidate for conducting this work. The indicator sets developed internationally by Scotland and by C. L. Keyes (2007) could be used to inform indicator development in Canada.

## **QUESTIONS FOR FURTHER CONSIDERATION**

1. What data does Canada already collect regarding positive mental health?
2. What are the facilitators and barriers to the creation of a national-level data set for positive mental health? How can these addressed to facilitate development of a robust data set?



## DEVELOPING MHP & MIP POLICY IN CANADA: KEY QUESTIONS FOR CONSIDERATION

Margaret Barry (2007: 3) has noted:

“It is now accepted... that the promotion and maintenance of mental health at a population level calls for a comprehensive approach, including effective policies and strategies at international, national, regional, and community levels. ... [A] supportive and favourable policy context is critical to ensure that initiatives to promote mental health are sustained (Scanlon, 2002)... Creating a mentally healthy society entails building up all three facets of the art (creative and effective practice), science (strong research and theory base) and politics (supportive government policies and political processes) of mental health promotion and working across diverse sectors in order to address the upstream determinants of mental health.”

The big question, then, is how can Canada build up the art, science and politics of mental health promotion and mental illness prevention to sustain effective action that addresses the upstream determinants of mental health and that will lead to a mentally healthy population?

Several questions have been posed in the preceding section:

- How can we work collaboratively across different levels and sectors and segments of society to promote mental health and prevent mental illness?
  - Who, specifically, needs to be engaged in the processes of developing and implementing MHP & MIP policies and plans?
  - What is the most effective way to engage these individuals, groups, communities, organizations and sectors?
  - Who will lead these processes of engagement?
  
- Which policy model is best for effective MHP & MIP in Canada?
  - How can MHP & MIP policy be designed such that it:
    - enables enactment of the fundamental principles of MHP & MIP
    - enables integration of MHP & MIP into mental illness treatment and services?
    - ensures a sustained emphasis on MHP & MIP actions?
  - How might cross-sectoral action for MHP & MIP be facilitated through policy design?
  
- What are the key elements to be included in a MHP & MIP policy for Canada?
  - Who will lead policy development and determination of policy content?
  - How will policy content and focus be determined?



- How can we support effective implementation at different levels and establish the infrastructure and resources needed?
  - Who shall lead implementation of MHP & MIP policy in Canada? How can we most effectively ensure sustained leadership and oversight of MHP & MIP policy implementation?
  - What existing bodies, policies and programs can support MHP & MIP action in Canada? Are new institutions needed to oversee MHP & MIP policy implementation and evaluation? Or is it possible to integrate MHP & MIP policies and plans into existing structures at the national, provincial/territorial and local levels?
  - What resources are required (financial, human, training, research, evaluation)? Are new funding mechanisms needed to secure these resources?
  - How can we facilitate and invest in research to guide MHP & MIP policy and practice?
  - How do we expand the knowledge base for positive mental health in order to effectively translate knowledge into practice?
  - How can we build capacity and train the workforce in public health and other sectors to prepare them to become enablers and advocates for MHP & MIP across sectors?
  - How can we sustain the engagement of key stakeholders in an ongoing and mutually generative and beneficial manner?
  
- How do we evaluate MHP & MIP policy impact to ensure accountability for mental health?
  - What data does Canada already collect regarding positive mental health?
  - What are the facilitators and barriers to the creation of a national-level data set for positive mental health? How can these be addressed to facilitate development of a robust data set?

These are simple questions, yet big ones, and they require thoughtful deliberation as the Mental Health Commission of Canada and other stakeholders move forward in developing a national mental health strategy. As Sainsbury (2003: 5) has noted about the difficulties associated with creating changes of this magnitude,

“I do not think that the problems are wholly dissimilar to those faced by the social reformers of the nineteenth century (Chadwick, Snow, Nightingale, Simon, Owen, Virchow, Shaftesbury, Engels, Mayhew, etc.). They had all of these problems and suffered many disappointments for every success... Yet many of us look back on them as heroes and heroines, and we regard the second half of the nineteenth century as a golden age for public health. Their values, energy, persistence and imagination should serve as beacons now as we try to create healthier, happier, more harmonious, more sustainable global societies.”

Daunting challenges lie ahead, but what is compelling is the prospect of success – a Canada where all individuals, families, communities and organizations thrive and flourish.



## GLOSSARY OF TERMS AND ACRONYMS

<b>Discrimination</b>	The way people living with mental illness are treated, intentionally or unintentionally, due to stigma. People with mental illness are often treated with disrespect, experiencing such behaviours as exclusion, bullying, aggression, ridicule and devaluation. Such discrimination can result in limits and barriers to many of life’s opportunities (Mental Health Commission of Canada, 2008: 4).
<b>Empowerment</b>	The basic framework upon which mental health promotion is constructed. Empowerment in mental health promotion can be understood as people and communities recognizing and fostering their own sense of personal strength through determining their own destinies and having the personal and material resources to do so in a supportive environment. Empowerment in mental health promotion also involves a sense of personal control: the feeling that one can rely on oneself or supportive others when facing difficult situations (PHAC, Online).
<b>Mental disorder</b>	A recognized, medically diagnosable illness that results in the significant impairment of an individual’s cognitive, affective, or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors and can be managed using approaches comparable to those applied to physical disease (i.e., prevention, diagnosis, treatment and rehabilitation) (Epp, 1988: 5). Also known as mental illness.
<b>Mental health (MH)</b>	The capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional, social, intellectual and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity (Public Health Agency of Canada, Online). Produced through dynamic interaction between individuals, groups and the broader environment (Epp, 1988), mental health is the foundation of well-being and effective functioning for individuals, families, communities, societies and communities.
<b>Mental health literacy</b>	Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Includes the ability to recognize specific disorders, how to seek mental health information, knowledge of risk factors and causes, self-treatments and professional help available, and attitudes that promote recognition and appropriate help-seeking (Commonwealth Department of Health and Aged Care, 2000: 5).
<b>Mental health strategy</b>	See “Mental health plan/strategy,” above.
<b>Mental illness</b>	See “Mental disorder,” above.
<b>Mental illness prevention</b>	Focuses on reducing risk factors and enhancing protective factors associated with mental ill-health, with the aim of reducing risk, incidence and prevalence and recurrence of mental disorders, reducing the time spent with symptoms or the risk condition for a mental illness, preventing or delaying recurrences and decreasing the impact of illness in the affected persons, their families, and society (Jané-Llopis et al., 2006:7).



<b>Population health</b>	A population-health approach focuses on improving the health status of the population. Action is directed at the health of an entire population or sub-population, rather than at the health of individuals. Focusing on the health of populations also necessitates the reduction of inequalities in health status between population groups. An underlying assumption of a population-health approach is that reductions in health inequities require reductions in material and social inequities. The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement (Public Health Agency of Canada, Online).
<b>Public mental health</b>	The art, science and politics of creating a mentally healthy society (Friedli, 2005: 1). It provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population (Friedli, 2004: 2).
<b>Resilience</b>	Individual resilience is the vital sense of flexibility and the capacity to re-establish one’s own balance; the essential feeling of being in control with regard to oneself and to the outside world (Public Health Agency of Canada, Online).
<b>Pathogenic</b>	Having to do with the production or causation of illness.
<b>Protective factors</b>	Those factors which reduce the likelihood that a person will experience a mental illness. They foster resilience in the face of adversity.
<b>Recovery approach</b>	“Whereas recovery from illness usually implies full remission, recovery from mental illness refers more to an individual’s own sense of mastery over his/her life and illness. Can occur while symptoms are still present. Consumer literature suggests recovery is a deeply personal, unique process of changing one’s attitudes, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life... [I]t involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric illness or the social consequences of the illness” (Pape & Galipeault, 2002: 12).
<b>Risk factors</b>	Those aspects of an environment that are associated with an increase in the likelihood that people will develop a mental illness.
<b>Salutogenic</b>	Having to do with the origins and production of positive states of health and well-being; an emphasis on factors that contribute to good health and how people manage to stay well despite the inevitable presence of stressors in life.



<b>Stigma</b>	The negative and prejudicial ways in which people living with mental illness are labelled. Often that means being labelled as nothing more than the disease itself. Stigma is an internal attitude and belief held by individuals, often about a minority group such as people with mental illness (Mental Health Commission of Canada, 2008: 4).
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<b>ACRONYMS</b>	
EU	European Union
EC	European Commission
IMHPA	Implementing Mental Health Promotion Action
IUHPE	International Union for Health Promotion and Education
MH	Mental health
MHP	Mental health promotion
MIP	Mental illness prevention
NGO	Non-governmental organization
PHAC	Public Health Agency of Canada
US	United States
WHO	World Health Organization



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## APPENDIX A: PAN-CANADIAN STEERING COMMITTEE FOR MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION

### **CO-CHAIRS**

Peter Coleridge  
BC Mental Health & Addiction Services

Beth Evans  
Alberta Mental Health Services Board

### **MEMBERS (IN ALPHABETICAL ORDER)**

Howard Chodos  
Mental Health Commission of Canada

Marion Cooper  
Winnipeg Regional Health Authority

Lori Idlout  
Embrace Life Council

Suzanne Jackson  
Centre for Health Promotion, University of Toronto

Sharanjeet Kaur-Sandhu  
Ontario Ministry of Health Promotion

Marianne Kobus-Matthews  
Centre for Addiction and Mental Health

Carl Lakaski  
Public Health Agency of Canada

Bonnie Pape  
Canadian Mental Health Association

Ken Ross  
Department of Health, New Brunswick

Andrea Stevens Lavigne  
Centre for Health Promotion, University of Toronto



## APPENDIX B: KEY INFORMANTS

NAME	AFFILIATION/POSITION	JURISDICTION
Dr. Eva Jané-Llopis	Department of Health, Government of Catalonia, Spain Radboud University of Nijmegen	EU/International Netherlands
Dr. Shekhar Saxena	Coordinator for Mental Health: Evidence and Research, WHO, Geneva	WHO/International
Dr. Margaret Barry	Professor of Health Promotion and Public Health, and Director, Health Promotion Research Centre, Department of Health Promotion, National University of Ireland, Galway  IUHPE Global Vice-President for Capacity Building, Education and Training	Ireland; International perspective also
Dr. Helen Herrman	Professor, Dept. of Psychiatry, University of Melbourne	Australia
Dr. Corey Keyes	Associate Professor, Sociology, Emory University, Atlanta, Georgia	US
Dr. Eero Lahtinen	Senior Medical Officer, Ministry of Social Affairs and Health	EU/Finland
Dr. Clemens Hosman	Professor, Maastricht University (Health Sciences) and Radboud University Nijmegen (Clinical Psychology), and Director of the Prevention Research Centre, located at both universities	The Netherlands
Dr. Alberto Minoletti	Director, Mental Health Department, Ministry of Health	Chile
Dr. John Raeburn	Adjunct Professor, Public Health and Psychosocial Studies, Auckland University of Technology  Former Director of Mental Health Programmes, Applied Behavioural Science, University of Auckland  Past Chair of the Mental Health Foundation of New Zealand	New Zealand
Mr. Gregor Henderson	Former Director of the Scottish Government's National Programme for Improving Mental Health and Wellbeing (2003–2008)	Scotland



## APPENDIX C: INTERVIEW GUIDE

### MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION POLICY BACKGROUND PAPER

Questions for Key Informant Interviews  
Kathy GermAnn and Paola Ardiles  
May 22, 2008

1. [Opening conversation re. briefly what we have learned about the MHP/MIP policy in the jurisdiction; seeking clarification and asking about any new developments or changes.]
2. Could you please describe your role in developing and implementing the MHP & MIP policy and/or strategy?
3. How was the MHP/MIP policy/strategy developed?

Probes:

- What people and/or circumstances spurred development of the policy/strategy?
- What factors/dynamics facilitated development of the policy/strategy?
- What barriers/challenges were encountered in developing the policy/strategy? How were these addressed? With what success?
- To what extent were multiple sectors/groups involved in developing the policy? How was this achieved?
- How was the long-term nature of MHP & MIP accommodated within the policy/strategy?
- Given your experience, what would you say are the critical elements of successful MHP & MIP policy/strategy development?

4. How has the policy/strategy been implemented so far?

Probes:

- What successes have been realized in implementing the policy/strategy to date? What innovative actions/approaches/solutions have been generated? What factors/dynamics have contributed to this success?
- What challenges have been encountered in implementing the policy/strategy? How have they been addressed? With what success?

To what extent has it been a challenge to integrate MHP into an illness-oriented system? If significant, how has this been addressed?

To what extent has intersectoral collaboration for MHP & MIP occurred? What factors/dynamics enabled and/or constrained collaboration?

To what extent have resources for implementation of MHP & MIP (e.g., research, information, trained personnel) been successfully developed/leveraged? What factors/dynamics enabled and/or constrained development or mobilization of sufficient resources for implementation?

5. If necessary: How is success of the policy/strategy being monitored/evaluated?
6. Given your experience, what advice do you have for us in terms of developing and implementing high level MHP & MIP policy/strategy in Canada?
7. What else should we know about your MHP/MIP policy/strategy that will help us move forward in Canada?



## APPENDIX D: SOCIAL DETERMINANTS OF HEALTH

<b>THE SOCIAL DETERMINANTS OF HEALTH</b>	
<b>DETERMINANT</b>	<b>DESCRIPTION</b>
<b>Income and social status</b>	Health status improves with each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.
<b>Social support networks</b>	Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships and the resulting sense of satisfaction and well-being seem to act as a buffer against health problems.
<b>Education and literacy</b>	Health status improves with level of education. Education contributes to health by equipping people with knowledge and skills for problem solving and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.
<b>Employment and working conditions</b>	Unemployment, underemployment and stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands on the job are healthier and often live longer than those in more stressful or riskier work and activities.
<b>Social environment</b>	The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province, or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others.
<b>Healthy child development</b>	Early childhood experiences influence brain development, school readiness and health in later life.
<b>Gender</b>	Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power, and influence that society ascribes to the two sexes on a differential basis. Gendered norms influence health system practices and priorities.
<b>Culture</b>	Some persons or groups may face additional health risks due to a socio-economic environment which is largely determined by cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

<b>Food security/ insecurity*</b>	Food insecurity is the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so (Davis & Tarasuk, 2004). There are psychological and social consequences as well as physical ones, including social exclusion and distress and depression in children and adults.
<b>Social inclusion and exclusion*</b>	Social exclusion is the inability of certain groups and individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources. Social exclusion leads to pronounced psychological effects and impacts negatively on health status.
<b>Housing*</b>	Affordable, suitable and adequate shelter is a prerequisite for good health. Living in substandard housing creates financial and psychosocial distress which negatively impacts health.
<p>Source: Public Health Agency of Canada, Online</p> <p>* Indicates descriptions of health determinants prepared by various authors for the 2002 Social Determinants of Health Across the Life-Span Conference. These descriptions, while located on the Public Health Agency of Canada website, do not necessarily reflect the views of Health Canada.</p>	