Toward Flourishing for All…

Proceedings of the National Mental Health Promotion and Mental Illness Prevention Think Tank

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LIST OF ACRONYMS	
CAMIMH	Canadian Alliance on Mental Illness and Mental Health
CHEO	Children's Hospital of Eastern Ontario
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CMHA	Canadian Mental Health Association
FNIHB	First Nations and Inuit Health Branch
F/P/T	Federal/Provincial/Territorial
FPTMHPIG	Federal Provincial Territorial Mental Health Promotion Interest Group
MHCC	Mental Health Commission of Canada
MHP	Mental health promotion
MIP	Mental illness prevention
NGO	Non-government organization
PHAC	Public Health Agency of Canada
SSHRC	Social Sciences and Humanities Research Council

TABLE OF CONTENTS

PURPOSE

On November 4, 2008, a number of mental health promotion (MHP) and mental illness prevention (MIP) stakeholders from across Canada, along with three international experts, gathered in Calgary, Alberta at the National Mental Health Promotion and Mental Illness Prevention Think Tank. The Think Tank was co-hosted by *Alberta Health Services – Alberta Mental Health Board* and *BC Mental Health and Addiction Services* in partnership with numerous other organizations, including:

- *Public Health Agency of Canada*
- *Mental Health Commission of Canada*
- *Centre for Addiction and Mental Health*
- *Canadian Mental Health Association*
- *Centre for Health Promotion, University of Toronto*
- *Department of Health, New Brunswick*
- *Embrace Life Council*
- *Ontario Ministry of Health Promotion*
- *Winnipeg Regional Health Authority*

The goal for the day was to provide an open and stimulating environment where interested stakeholders from across Canada could:

- Review and analyze mental health strategies in jurisdictions outside of Canada with a particular focus on mental health promotion and mental illness prevention; and,

- Contribute recommendations to an integrated mental health strategy for Canada.

The purpose of this document is to present the key ideas and recommendations for developing and implementing mental health promotion (MHP) and mental illness prevention (MIP) policy in Canada that were generated by participants in the Think Tank.

BACKGROUND

The Think Tank grew from several earlier efforts, beginning with a Mental Health Promotion Summer Institute held in 2005 in Toronto, Ontario. 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 mental health promotion policy in Canada.

Two years later, *BC Mental Health and Addiction Services*, in partnership with other stakeholders, hosted a mental health 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, Alberta Mental Health Board, British Columbia 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 (MHP), but also a desire to stay connected, learn more, and ideally, influence MHP in Canada.

Following the symposium, conversations continued among a group of enthusiastic mental health promotion experts from across Canada. This group evolved into the *Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention* 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 policy work, and to help inform mental health promotion and mental illness prevention policy development and implementation at the provincial and territorial level. [See Appendix A for a list of Pan-Canadian Steering Committee Members.]

To inform deliberations at the Think Tank, a policy background paper - "Toward Flourishing For All… Mental Health Promotion and Mental Illness Prevention Policy Background Paper" – was commissioned[1]. In this paper, efforts of other jurisdictions in developing and implementing national-level MHP and MIP policies and plans were examined with the intent of informing possible actions in Canada. Five key questions for consideration in developing and implementing MHP & MIP policy were proposed in the paper. These questions (and several sub-questions) formed the basis of small group discussions at the Calgary Think Tank.

ORGANIZATION OF THE PAPER

In the next section, a brief overview of activities that occurred at the Think Tank is provided. This is followed by presentation of key ideas and recommendations raised by Think Tank participants over the course of the day. Remarks made at the end of the day by three international experts (Dr. Corey Keyes, Dr. Margaret Barry, and David McDaid) and Dr. Howard Chodos of the Mental Health Commission of Canada constitute the third section of the paper. The paper is concluded with a summary of remarks made by the Think Tank co-chairs, including "next steps" for moving forward from the Think Tank.

[1] A second document, *Toward Flourishing for All Companion Document. Mental Health Promotion and Mental Illness Prevention in International Jurisdictions*, was also prepared. This document provides detailed information regarding MHP & MIP policies in other jurisdictions.

PROCESS FOR THE THINK TANK

The Think Tank agenda can be found in Appendix B. The day commenced with greetings from each of the Think Tank co-chairs, Beth Evans (Alberta Health Services – Alberta Mental Health Board) and Peter Coleridge (BC Mental Health and Addiction Services). Sandra Crazy Bull, Aboriginal Outreach Worker from the Glenbow Museum, and a renowned Fancy Dancer on the pow-wow trail, also welcomed participants to Calgary.

Madeleine Dion-Stout of the Mental Health Commission of Canada then provided an update on development of the National Mental Health Strategy by the Mental Health Commission of Canada (MHCC). The Commission has a keen interest in mental health promotion and mental illness prevention as these are essential for reducing the burden of mental illness and enhancing the well-being of all Canadians. The Commission is currently developing a national mental health strategy for Canada and will release a public consultation document in December. The document will set out high level goals for what a transformed mental health system might look like in Canada. Once the public consultation is completed, the Commission will work with other sectors and population groups to achieve the goals for a transformed system. Ms. Dion-Stout said she was looking forward to receiving focused and strategic advice for enhancing mental health promotion and mental illness prevention in Canada.

Next, Dr. Suzanne Jackson (University of Toronto) told participants that the Pan-Canadian Steering Committee was interested in contributing to development of the national mental health strategy by focusing on mental health promotion and mental illness prevention. She presented highlights of the policy background paper, "Toward Flourishing for All". Mental health promotion, she said, is defined as "the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. It uses strategies that foster supportive environments and individual resilience while showing respect for culture, equity, social justice, interconnections and personal dignity[2]". Dr. Jackson outlined several reasons to invest in MHP and described the keys to success and challenges across jurisdictions that were presented in the policy background paper.

Dr. Jackson then provided an overview of activities for the remainder of the day. The primary activity was small group discussions centred on five key questions (and several sub-questions) that were outlined in "Toward Flourishing for All". The key questions included:

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

2. Which policy model is best for effective mental health promotion and mental illness prevention in Canada?

3. What are the key elements to be included in a mental health promotion and mental illness prevention policy for Canada?

4. How can we support effective implementation at different levels and establish the infrastructure and resource needed?

[2] Health Canada, 1997. *Proceedings of a workshop on mental health promotion.* Centre for Health Promotion, University of Toronto and Mental Health Promotion Unit, Health Canada. Ottawa: Health Canada, pp.4-5.

5. How do we evaluate mental health promotion and mental illness prevention policy impact to ensure accountability for mental health?

Think Tank participants then assembled in pre-assigned small groups to discuss these questions and to generate key recommendations regarding each of these questions. The small group discussions were facilitated primarily by the Pan-Canadian Steering Committee members who were given the privilege of offering their own insights and ideas. In the morning, each group discussed two of the first three questions (working collaboratively across sectors, policy design, and key elements). After a lunch break, key recommendations arising from the morning discussions were presented to the large group. The small groups were then re-assembled to repeat the process with the remaining two questions. This time, all groups responded to both questions (implementation, and evaluation of MHP and MIP policy).

Having observed and participated in the group discussions, three international experts – Dr. Corey Keyes (Emory University), David McDaid (London School of Economics), Dr. Margaret Barry (National University of Ireland) - and Dr. Howard Chodos (Mental Health Commission of Canada) provided their reflections on the day's discussions.

The day was concluded with remarks from the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention co-chairs, Peter Coleridge and Beth Evans.

KEY IDEAS AND RECOMMENDATIONS

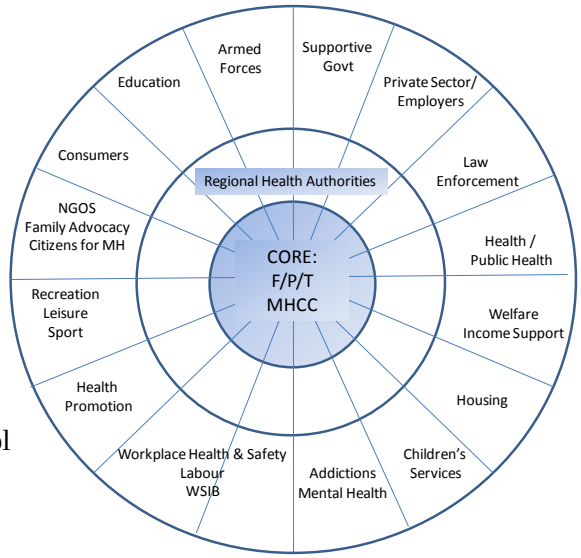
Question One: How can we work collaboratively across different levels and sectors and segments of society to promote mental health and prevent mental illness?

Who needs to be engaged in the processes of developing and implementing MHP and MIP policies and plans?

Think Tank participants listed numerous groups and organizations that need to be engaged in policy development and implementation. These included:

- Civil society:
  - Representatives from across the life-span
  - Representatives from different settings
  - Community groups and organizations
  - Cultural groups (e.g., new Canadians/immigrants; First Nations, Metis, and Inuit peoples)
  - People at risk for developing mental illness
  - People experiencing mental illness
- Non-government organizations (e.g., Canadian Alliance on Mental Illness and Mental Health [CAMIMH], the Canadian Mental Health Association [CMHA])
- Mental Health Commission of Canada (MHCC)
- Government at local, provincial, and federal levels. One group noted that provincial governments need to become more involved. Several actors at the federal level were listed by groups, including:
  - Public Health Agency of Canada (PHAC)
  - The Federal/Provincial/Territorial Mental Health Promotion Interest Group (FPTMHPIG)
  - First Nations and Inuit Health Branch (FNIHB)
- Health sector:
  - Pre- and post-natal health; maternal/child health
  - Healthy families
  - Mental health
  - Health promotion

- Other sectors and initiatives. One group developed the diagram below to identify key stakeholders. Other groups listed the following stakeholders:
  - Family violence prevention
  - Poverty reduction
  - Immigration (e.g., immigration transitions)
  - Employment
  - Religious and spiritual leaders (especially when working with immigrant and First Nations, Inuit and Metis people)
  - Recreation/leisure/sports/arts
  - Education (e.g., Joint Consortium for School Health)
  - Employment
  - Justice
  - Life transitions (e.g., retirement planning, planning for life)
  - Private sector and philanthropy
  - Universities
  - Global E-Scan Round Table on Mental Health in the workplace
  - AFH/ITK



What is the most effective way to engage these people?

- **Need for a national framework.** One group noted a need for a global, comprehensive and coordinated framework to undergird policy work. This framework must include measurable and tangible outcomes.

- **Collaboration requires strong leadership.** One group suggested a new national-level group or committee could lead collaborative processes to engage the diverse stakeholders listed above. Membership in this group could include people from the MHCC, PHAC (e.g., MHP Interest Group), FNIHB, mental health NGOs, other NGOs, other sectors (e.g., school health), community-level groups, and representatives from across the lifespan. In contrast, another group suggested that each jurisdiction should identify leaders that suit the local context.

- **Grass-roots engagement and mobilization.** All three groups noted the importance of engaging a cross-section of civil society in policy development. One group noted the best solutions come when communities define their own issues and as such, there is a need for "grass-roots" involvement and mobilization - i.e., the creation of a social movement that will create public demand for mental health.

- **Engaging other sectors.** All groups discussed the importance (and challenges) of engaging other sectors in MHP policy development and implementation. All noted the need to find ways to articulate the "value added" of good mental health in terms of other sectors' goals. Thus, it is important to make MHP appealing to the focal interests of each sector. One group noted it would be helpful to look at good examples of things that are already going on in different sectors (e.g., urban renewal, income support) that *are* in essence MHP – and help people in other sectors to realize they are already doing MHP. Groups discussed the importance of flexibility in language use and of seeking common understanding when working with other sectors. One group mentioned the value of identifying common policy needs with other sectors. Another noted the importance of engaging stakeholders early on in the process.

Who will lead these processes of engagement?

- One group recommended the following: Mental Health Commission of Canada, Public Health Agency of Canada, and Federal/Provincial/Territorial MHP Interest Group as leads but also noted that implementation would be the responsibility of many others.

- Another group suggested co-leadership between population/public health and mental health.

- Another group noted that different levels of leadership are required. Leaders could actively engage others at each level (e.g., federal, provincial/territorial, local/regional, school health) and connect to the next level up, and bring other sectors into the process.

Participants also identified challenges associated with engaging others, including:

- Limited understanding of (and success in) collaborating across government sectors, although there are some examples of success (e.g., five groups in Ontario that identified three specific MHP goals and specific action areas as a way of promoting collaboration).

- A lack of compelling evidence that MHP works; the best available evidence is for children.

- The importance of service-users being at the table, but the tension between MHP for all and an emphasis on service users. It was noted that conditions favourable to recovery may help bridge the divide between MHP and MIP. It was also noted that there is a false dichotomy between MHP and service provision. The services system is amenable to change and is capable of doing MHP work.

Suggestions for fostering engagement included:

- Creating a shared understanding is critical. A compelling vision helps cross boundaries.
- MHP needs to be made appealing to the focal interests of other sectors.
- Build on the current momentum for MHP and set a clear time-frame to see results.
- Have a MHP champion.
- Provide funding streams.
- Make the economic argument for why MHP and MIP are worth investing in.

- Draw from the example of the European Union where member states achieve consensus on priorities and sign on to measurable outcomes and reporting of same.

KEY RECOMMENDATIONS REPORTED BACK TO THINK TANK PARTICIPANTS

1. Communities need to define needs.

2. Policy should follow effective practice.

3. Conversation must occur at grass roots re: MHP connections.

4. Make the economic argument for why MHP and MIP are worth investing in.

5. Government needs a framework, but MHP and MIP require targeted interventions that engage people at different levels and sectors. The framework must include measurable and tangible outcomes. The action has to happen locally.

6. Take the example of the EU where member states, via consensus, sign on to measurable outcomes and reporting of same.

7. This will not be the exclusive purview of any one national body (e.g., MHCC, which will do some MHP and MIP work but not all that needs doing).

8. Should we be looking at international affiliations (e.g., EU, WHO standards for evaluation and monitoring standards)?

9. Many priority populations, but a particular emphasis on children and youth for MHP and MIP (best evidence base) and First Nations, Metis, and Inuit people.

10. Research that involves multiple sectors is needed so that the outcomes measured are not exclusively mental health outcomes.

11. Collaboration: early engagement; change management process (address barriers and facilitators to change); business case (value propositions – make link for each sector/context).

12. Who leads? Co-lead – population and public health and mental health. Each jurisdiction needs to identify leads that make sense. Be flexible with language. Mobilize the community (social movement, public demand for mental health). Identify common policy needs in other sectors.

Question Two: Which policy model is best for effective MHP & MIP in Canada?

Key ideas included:

- **A "whole of government" approach.** One group recommended a "whole of government" approach that integrates mental health into broader social policies. The group identified the following characteristics of such an approach:

    - Mental health would be a thread in every policy; a mental health lens would be applied to all public policy at all levels
    - Policy modeled on meaningful public participation (community networks)
    - Engaging and galvanizing the public (including consumers and families)
    - First Nations, Metis, and Inuit self-determination
    - Distributed accountability and cross-government agreements re: mental health
    - Establishment of common outcomes across ministries
    - Actions across the life span, and different settings and populations

The group further noted that a whole of government approach:

- would support the important role played by the environment and social determinants of mental health;
- would help eliminate discrimination of people experiencing mental illness;
- must be part of a comprehensive approach that includes access to treatment, prevention and promotion; and,
- could be challenging in terms of getting all departments together and reaching a common understanding.

Key considerations regarding this policy design include the need:

- for strong government leadership especially at the national level, with implementation at the provincial/territorial level;
- for broad consultation since moving to MHP & MIP requires the drive from public demand;
- to look beyond the life of the strategy and the Commission itself; and,
- to determine accountability mechanisms, delivery structures and reporting systems.

- **A comprehensive national MHP & MIP policy.** Another group recommended a comprehensive, national MHP & MIP policy embedded and championed at all levels, including:

    - Mental health policy
    - Public health
    - Social policy

  This group also recommended, from a pragmatic perspective, taking advantage of existing structures and opportunities (e.g., MHCC, PHAC, provinces and territories, CIHR, Statistics Canada).

- **Shared leadership.** A third group recommended shared leadership outside the health sector, but including health, along with workplaces, schools, CHCs, and municipalities. Public health could pull these groups together. The group challenged: "dare to be unconventional, innovative". It also recommended inclusion of people living with mental illness, based on a recovery model and anti-stigma.

KEY RECOMMENDATIONS REPORTED BACK TO THINK TANK PARTICIPANTS

1. A comprehensive, national MHP & MIP policy that is embedded and championed at all levels – mental health, public health, social policy.

2. Take advantage of existing structures and opportunities (e.g., MHCC, PHAC, provinces/territories, CIHR, Statistics Canada.

3. Use a whole of government approach – population, intersectional lens, lifespan, settings, policy modeled on public participation, social determinants of health, First Nations, Metis and Inuit self-determination, distributed accountability, cross-government agreements, establish common outcomes across ministries, language, and galvanize the public.

Question Three: What are the key elements to be included in a MHP & MIP Policy for Canada?

Key ideas and recommendations arising from discussions of this question have been organized into three categories: general considerations, overarching principles, and specific elements for inclusion in MHP and MIP policy.

- **General considerations and possible approaches*:***
  - **A national framework with implementation at provincial and local levels.** It would be useful to create a national framework for MHP and MIP, but with priority setting and implementation at provincial and local levels. This framework should include MHP and MIP that spans the entire population, includes social determinants of health, adopts an ecological approach. It should be grounded in human rights, social justice, and cultural relevance.
  - **Leadership for development at different levels.** Policy development needs to be led at different levels with roles articulated for each – national/federal (e.g., PHAC, MHCC), provincial/territorial, local government, community
  - **Create and maintain a social movement.** Focus on broad engagement.
  - **Framing issues and language.** Attention must be paid to language and framing the message about MHP and MIP. The language used should match the context, and it should be positive. Clear definitions should be used and/or developed.
    - Three groups suggested MHP and MIP should be framed in terms of economic feasibility. MHP can be framed as a low cost – high benefit approach. A business case regarding the benefits of MHP and MIP should be made. The costs of NOT doing MHP & MIP should also be articulated.
    - Another group discussed the importance of accountability mechanisms – (e.g., accreditation, legislation, federal/provincial/territorial agreements, reporting, indicators)
  - **A balanced approach** should be adopted that reflects both MHP and MIP. The approach should also incorporate future thinking as well as current needs regarding mental illness services and supports.

- **Overarching principles:**
  - Adopt the Health Canada definition of MHP with the addition of "improve mental, physical, emotional and spiritual health and well-being". [*This would translate to: "The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental, physical, emotional and spiritual health and well-being."*]
  - Collaboration
  - Inclusion
  - Social justice

- Interrelationships among all components
- A strengths-based approach
- Resilience
- Empowerment
- Capacity building
- Efforts and strategies should consider diversity and be culturally appropriate
- Build on what already exists (will require mapping of existing initiatives, programs and resources at different levels)
- A single policy or program, well-designed, can achieve multiple, positive outcomes across different domains
- Policy should be based on best practices and evidence and community/consumer experience

➢ **Policy content and focus:**

- Focus on evidence-based approaches (e.g., social inclusion, freedom from discrimination and violence, and economic resources)
- Anti-stigma campaign as part of a full reform of services
- Balance anti-stigma with wellness promotion
- Anti-stigma campaign should use a broader definition of health to emphasize the idea that there is no health without mental health
- Embrace messages of wellness in ways that free or enhance peoples' ability to act
- Use strategies that foster supportive environments and family and individual resilience
- Policy that supports components in a number of areas – improving health literacy, focusing on mental health, addiction and mental illness, suicide prevention, early intervention/prevention of addiction, discrimination and stigma. Target key populations, vulnerable groups and settings, and families. Needs to be multiple levels, across sectors, across the continuum of early intervention, treatment, recovery.
- Evidence - available to everyone, build on Canadian examples, focus on solutions and success; support evidence gathering with long- and short-term funding.
- Focus – universal, communities, individuals

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

Responses have been compiled by theme rather than by group.

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?

- **General considerations:**
  - **Need for sustained leadership.** Lead body needs a long-term sustainability. [One group noted it is important to look beyond the MHCC's 10 –year mandate.] Strong and consistent leadership is needed to develop a national plan with local and provincial implementation.
  - **A clear understanding of roles and responsibilities is required.**
  - **National leadership but provincial/territorial implementation.** Several groups recommended national or federal leadership to develop policy and provide high-level leadership, but provinces/territories and local groups would set priorities and implement the policy. Other groups recommended:
    - National strategy with resources that flow to the provinces/territories with "teeth"/strings attached. Presented as an addition to provincial/territorial resources.
    - Collaborative leadership "with teeth" – MHCC, PHAC, provinces/territories, NGOs with clear accountabilities
  - **Mapping existing bodies, policies and programs that support MHP & MIP.** Five groups recommended mapping of existing bodies, policies, and programs that support MHP and MIP in Canada. This would help to know "who is doing what" at present, to identify gaps, and build on existing strengths.
  - **Mapping of best/promising practices.** Several groups recommended mapping of best/promising practices in MHP and MIP.
  - The upcoming **Senate Report** on the social determinants of health may be informative (e.g., examination of what they will be recommending for implementation).

- **Possible leaders for MHP & MIP policy implementation:**

It is important to note that no group identified a single leader to implement MHP and MIP policy; rather, various configurations were suggested. Joint leadership by the MHCC and PHAC seemed to be implied by many groups, as does national or federal leadership with provincial/territorial and local priority setting and implementation. Some groups recommended more collaborative and networked structures for leading implementation. Details are provided below.

- **Mental Health Commission of Canada (MHCC).** At least four groups recommended a leadership role for the MHCC. The organization was viewed by some groups as a potential catalyst for action, or as providing a broad vision for MHP and MIP in Canada.

    - One group noted the challenge of reconciling leadership with the realities of federal/provincial/territorial governance. This requires a non-political, non-federal body such as the MHCC. The MHCC could lead and provide a broad vision for MHP & MIP; federal/provincial/territorial governments (ministers and deputy ministers) could lead implementation.
    - Should the MHCC have an advisory committee on MHP? It would then be able to map onto the strategic directions of the MHCC.
    - MHP must be part of the MHCC's national mental health strategy – not as an add-on, but front and centre.
    - MHCC collaborating with three or four other national bodies to lead MHP, precisely because so many of the social variables that ultimately are involved in MHP are beyond the scope of the MHCC. Who will the other partners be?

- **Public Health Agency of Canada (PHAC).** At least four groups considered a leadership role for PHAC:

    - The provinces and territories have authority, but a federal incentive is required. Could Health Canada and PHAC provide some kind of incentive to the provinces and territories?
    - What about PHAC? There is a small mental health group within it. A MHP interest group that reports to PHAC could be an important linkage and an existing body supports this.
    - PHAC in its policy-setting stewardship role could be the lead/champion for MHP/MIP and work closely with the MHCC (content and expertise) and Health Canada (FNIHB and Addictions). MHCC could function as facilitators to content expertise and implementation. It could support innovation and knowledge exchange and evaluation and take a national coordination role (i.e., mobilization of partners and social movement).

- An **inter-ministerial collaboration or new agency** (e.g., VicHealth) at the provincial/territorial level

- **Networked and collaborative leadership**. Some groups recommended collaborative leadership for policy implementation. One group, for example, recommended a "network of networks" (a national movement) – and provision of tools for connecting at all levels:

    - Broad community support
    - Sharing understanding, leadership, and ownership of outcomes
    - Build and sustain an infrastructure to lead with MHCC as catalyst and a separate champion group

    Another group identified **potential leaders and partners** in a collaborative approach, including:

- MHCC
- PHAC
- Provinces and territories
- NGOs – to lead a social movement
- WHO and other international organizations
- CIHR
- Community model
- Grass roots – create a groundswell

One group recommended **reviewing the EU Charter on Counteracting Obesity** as a model for bringing different levels of government and sectors together (at First Ministers level) to develop and implement a MHP policy in Canada (e.g., First Ministers' Conference).

Another group noted implementation should occur through **engagement of different sectors** including new partners (e.g., corporate, religious sectors, population groups, First Nations, Metis, Inuit peoples, immigrant groups) to develop a **bottom-up approach** which includes government and other sectors to promote individual and communities to act as change agents.

Another group noted it would be valuable to learn from the AIDS community in terms of **creating a social movement.**

What existing bodies, policies, 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?

One group suggested that given the new economic reality, the likelihood of additional money for MHP is low; thus, it is better to work with existing agencies, organizations and infrastructures (e.g. school health). Some identified groups included:

- **CMHA** has national, provincial and territorial and local presence and is not focused exclusively on service delivery. It also has grass roots involvement locally.
- **NGOs** play a key role (CMHA, NGOs, CAMIMH, and others).
- **MHCC** can partner with other existing national bodies (e.g., advocacy groups, alliances, networks, etc.) as MHCC may not be the best implementer for actual delivery.

What resources are required (financial, human, training, research, evaluation)? Are new funding mechanisms needed to secure these resources?

- One group noted this question cannot be answered until existing structures are mapped out.
- Another group noted that resources are required for:
  - Infrastructure
  - Workforce development

- Purposeful knowledge exchange and transfer
- Mechanisms that support uptake of knowledge
- Collaborative efforts

- Transition or innovation funding
- Demonstration projects

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?

- PHAC has a portal and MHCC is developing a knowledge exchange centre

- CIHR – Population Health is already doing a cross-cutting theme for all institutes. Population Health Institute; Neuroscience, Mental Health and Addictions Institute. Could there be an RFP related to MHP & MIP? Overall, there is no need for a new and separate institute.

- CIHI's Population Health Initiative should try to address the gap in MHP research in Canada, perhaps through special competitions.

- There is a need for more participatory research that engages service users at CIHR; these research projects tend to go more to SSHRC. Recognize the need for sustainable funding whether through innovation and/or transition funds to address the gaps in participatory research methodologies to address MHP.

- An assessment of existing knowledge, gaps, and what we need to know is required.

- Promising practices research is needed.

- Research regarding the percentage of fiscal resources in provinces with a ministry devoted to health promotion in general and MHP in particular versus provinces that don't have such a ministry would help inform decisions about government structures to support MHP & MIP.

- Research is needed regarding the benefits (including economic benefits) of investing upstream in MHP. This represents a new area of inquiry. The federal government needs to invest new money and work with CIHR, MHCC and others to run a special joint call for research in MHP and economic evaluation.

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?

- **Create workforce specialists** capable of delivering programs and services across the lifespan.

- **Train, educate and support a consultation role** to build professional capacity in MHP over the long-term (2-3 centres across Canada).

- **Curriculum reform** in various training programs.

- **Information to the front lines** (e.g., through knowledge exchange centre of MHCC; needs to be in plain language, accessible, and applicable locally; and delivered by push technology rather than waiting for people to go to the websites).
- **Need to engage CPHI** in order to develop and support workplace capacity, knowledge exchange and evaluation.

How can we sustain the engagement of key stakeholders in an ongoing and mutually generative and beneficial manner?

- Adopt an **integrative and collaborative** approach
- Adopt a **focused, strategic** approach
    - Strive for quick wins
    - Need short, medium, and long-term results with focused efforts (e.g., populations [e.g., children and youth]; sectors [e.g., justice, education]; and settings [e.g., schools, workplaces])
    - Build on the strongest evidence
- **Leverage the recovery model** to garner support for MHP & MIP

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

Responses have been compiled by theme rather than by group.

A general comment from one group was that Canada has a national data system focused on mental illness indicators with no information on certain populations (e.g., First Nations, Metis, and Inuit) and a lot of variability across provinces and territories.

What data does Canada already collect regarding positive mental health?

- CIHI will soon be releasing a report on positive mental health indicators
- CHEO – indicators of positive mental health in children
- Children's Health Policy Centre at Simon Fraser University – has a monitoring framework for children's mental health from a population health perspective
- National Longitudinal Survey on Children and Youth
- Canadian Community Health Survey
- Healthy Aging
- Life Satisfaction data
- Employers and insurance plans may have data
- National Quality Institute Health Card
- School surveys

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?

- Existing data doesn't include special populations
- Need for trust in identifying issues for special/sub-populations (e.g., First Nations, Metis, Inuit)
- Getting buy-in and agreement to collect data
- Variation in resources, capacity, systems to collect and analyze data, and in provincial/territorial statutes regarding privacy
- Positive mental health and MHP aren't necessarily valued by all

Recommendations for Monitoring

- **Need for consensus on a core set of national positive mental health indicators.** Numerous groups pointed out the need to establish a common matrix/indicator framework for positive mental health for Canada. One group suggested the additional need for provincial/territorial capacity to add other local indicators.

- **Suggestions for specific indicators** included:
  - Broaden Statistics Canada's/CIHI's existing framework
  - Population well-being
  - Balance well-being and illness
  - Shift from outputs to outcomes
  - Recognize and capture diversity in all its forms (e.g., gender differences, age, ethnicity, sexual orientation)
  - Changes in attitudes/knowledge
  - Indicators that capture resilience, well-being (e.g., Keyes' model)
  - Community mapping and qualitative stories of well-being of Canadian communities
  - Indicators of costs and benefits of MHP and MIP
  - Assess currently available data and apply a mental health lens
  - Some existing data collection tools could be adapted to MHP & MIP and for different jurisdictions

- **Recommended actions** included:
  - A set of commonly accepted indicators should be established NOW to create an initial baseline.
  - A national champion could spotlight how to use existing data, information, and knowledge more effectively.
  - Hold a national consensus conference to achieve agreement on a common matrix/indicator framework for positive mental health in Canada.
  - Resource appropriately.
  - Build on provincial and territorial infrastructures.
  - Engage and collaborate with national organizations that collect data to fill data gaps and enhance existing data; cohesiveness is critical and data must be accessible.
  - PHAC's Collaborating Centre for the Social Determinants of Health could be the monitoring centre for MHP/MIP indicators.
  - Ensure continuity of data.
  - Cautions about data:
    - Don't over-rely on data.
    - Track who is using data to effect change.

- Information and knowledge are needed along with data.

- What about CIHI as the monitoring agency – broadening its health-related indices to include mental health and the social determinants of mental health? They need to see this as part of their mandate.

- Indicators could be linked to accreditation, policy reviews and program evaluation.

Recommendations for Evaluation

- Principles:
  - Create a definition of success and milestones along the way.
  - There must be accountability for success, positive mental health indicators (e.g., health care accountability standards).
- Action plans with measurable outcomes – short, medium, long-term – are necessary and feasible
- There are few evaluated interventions in MHP. Resources are needed to develop capacities for evaluation, tools, and indicators at the field level in MHP.

DISCUSSANT RESPONSES

At the end of the day, three international experts and Dr. Howard Chodos of the Mental Health Commission of Canada provided their reflections about the day's discussions. Their remarks are presented below.

Dr. Corey Keyes
Associate Professor, Sociology
Emory University, Atlanta, Georgia

Dr. Keyes noted that he often hears comments that academics are "pie in the sky", "too rational", "too academic". But what he heard in the group discussions was pretty generic and he wondered if this is what the participants really want for Canada. He challenged participants to "put up or shut up". "In every country I've met", he said, "academics and politicians suffer one affliction – the wanting, doing gap. We have to get over this. We say we want health, but then we wind up focusing on illness and treatment".

Keyes argued it is impossible to treat our way out of the growing problem of mental illness. Treatment is only half the way there. If you want *health*, you have to focus on *health*, and health is *not* about the absence of disease. Talking about disease won't get you to health. Illness is very specific; health is something positive. People have argued that disease is easy to measure, but health is not. This is not true. In fact, people have been measuring health for over fifty years. Well-being *can* be measured – it consists of emotional, psychological and social well-being. It is about hedonia and eudaimonia – feeling good about life and doing well, and this can be measured!

Keyes went on to note that people often believe that health and illness exist on a single continuum, and even those who say they don't believe this often still follow this thinking. In a recent study, Keyes found that only 2 in 10 Americans are flourishing. Mental health matters whether one has a mental illness or not, thus it is crucial to promote health. Mental illness is indeed a burden to society, but too little flourishing is just as serious as too much mental illness. In other words, anything less than flourishing is a burden.

Dr. Keyes noted further that, "We believe illness is more serious. In the end, politicians and policy-makers are saying illness is more serious than health". But, loss of mental health precedes mental illness. In his recent study, people who went from flourishing to only moderately flourishing had a two-fold increase in mental illness. But those who went from moderate mental health to flourishing had the lowest rates of mental illness. In fact, increasing mental health was linked with reductions in a number of chronic diseases. Thus, promoting mental health is a "two-for-one" – you get lower rates of mental illness by promoting mental health, *and* you get lower rates of chronic disease. "Finding a cure for mental illness is a great idea, but is it possible, given that there are over 300 syndromes?", Keyes asked. Promoting mental health makes more sense, he said.

To conclude, Keyes asked, "So what are you so tentative about? What are you afraid of? The science supports you – we can measure this – so let's get on with it!".

Dr. Margaret Barry

Professor of Health Promotion and Public Health
Director, Health Promotion Research Centre
Department of Health Promotion
National University of Ireland, Galway

Dr. Barry noted the development of a national mental health strategy is a unique and important opportunity to get mental health promotion on the agenda. The World Health Organization has stated a comprehensive approach that includes treatment, recovery, and rehabilitation and *also* mental health promotion and prevention is the way forward. In Canada, development of a mental health strategy is an opportunity to get it right.

There is international momentum for MHP. An increasing political focus on the well-being of societies will give a language to use around this and underpin its focus. This is important because it is a positive focus and is a key part of the health improvement agenda. However, this does require a paradigm shift – a focus on positive mental health, as opposed to mental disorders, at the population and individual levels of action. Canada is well-placed to build on strengths, given its public health infrastructure and a very strong legacy in health promotion. This provides a solid foundation for mental health promotion.

A key principle of mental health promotion is building on strengths. Accordingly, it will be important in Canada to map existing capacities, resources and barriers to MHP. This can be done as part of the process of building up MHP. In terms of a policy model, there were discussions during the day about adopting an all-of-government approach because the key drivers of mental health are outside of the health arena and reach across sectors. Dr. Barry noted that British Columbia already has an inter-governmental mechanism in place for public health improvement and this inter-sectoral policy model can also work for mental health promotion.

A key point raised by Dr. Barry was that even if mental health promotion gains prominence in the mental health strategy, a lot of thought must be given to *implementation* of MHP and MIP. Looking at the international models, many policies have been published with good aims and objectives, but they fall short in the implementation phase. Canada needs to look at this and work through the issues. An important consideration is the mental health promotion workforce in Canada. Who has the necessary skills to drive MHP on the ground? Dr. Barry noted, "There is a base of expertise and skills, and yes, mental health is everyone's business, but if no one is driving it, it's nobody's business". So, it is crucial to look at building workforce capacity and having a core of specialist mental health promotion workers who can act as catalysts for change and bring others in the wider workforce along. Building capacity for effective delivery still needs to happen in many countries.

Another key point raised by Dr. Barry was that a whole of government approach needs to be based on good engagement of the public. It was commented on during the day that Canadians value their mental health. But so far, the mental health area has been largely dominated by experts. The discussion needs to be opened up because mental health is a concern for everyone. Stronger mechanisms are needed for public engagement in the dialogue about mental health and mental health promotion, and to mobilize demand for creating mentally healthy societies and an intolerance of environments and conditions that are toxic to mental health.

Another issue is that many jurisdictions have had success in anti-stigma and suicide prevention programs. But where most countries haven't moved forward is in implementing generic mental health promotion. Dr. Barry suggested that Canada look at key priority areas for generic mental health promotion - for example, promoting mental health in the early years. In addition, she suggested engagement in the area of health inequalities as mental health may be seen as both a consequence of, and a contributor to, existing inequalities.

Finally, Dr. Barry noted that often across a country, there will be patches of excellence in MHP, characterized by good policies and initiatives. The task, however, is to scale that up to make sure this excellence is at a scale and scope necessary to make a critical difference.

Dr. Barry concluded that participants need to look forward to MHP and MIP having a strong place in Canada's mental health strategy, but that it is also important to look beyond the strategy and the Mental Health Commission of Canada to sustained policy implementation into the future. In particular, it is important to consider who will provide national leadership and galvanise action for future developments in this area.

David McDaid
Research Fellow in Health Policy and Health Economics
London School of Economics
Editor of Eurohealth

David McDaid noted that despite the challenges ahead, Canada is well-positioned for progress in mental health promotion and mental illness prevention. Having the Mental Health Commission of Canada in place with a ten year time frame is very positive.

Mr. McDaid told participants he was encouraged that many discussions throughout the day had highlighted the costs of mental illness. He noted, "We can't forget that money does talk – it is one way of getting different issues across to policy-makers and other sectors". The other positive news, he said, is that the economic argument for mental illness prevention is extremely strong, especially in early intervention with children and in the workplace. More work is needed, however, to determine the economic benefits of promoting positive mental wellbeing. This has been neglected because it is easier to look at the benefits of preventing disease. But MHP advocates need to start using these arguments. Even given Dr. Keyes' passion, people will ask about the economic benefits of promoting mental health. This might be an area of research in Canada, especially since Canada has a strong health economics community.

Another point raised by McDaid was that MHP and MIP advocates need to think about how good mental health can contribute to the goals of other sectors (e.g., education, workplaces). This is necessary to convince these people that promoting mental health will benefit their own endeavours. It is possible, for example, to point out the impact of mental health on educational performance or stopping bullying in schools. McDaid thus urged participants to increase their efforts to talk with people from other sectors – to build alliances and to think outside the box (e.g., benefits to physical health and other non-health outcomes).

McDaid went on to say that the current disconnection between public health and mental health is a barrier. These communities currently aren't doing enough to work together. Public health focuses primarily on physical health, but not mental health, and vice versa. Neither is looking at the other's focus. Yet, many actions on the social determinants of health are about both mental health *and* physical health.

Another issue observed by McDaid was that of engagement and getting this message across in terms of implementation. In a number of provinces, there are ministries of health promotion or healthy living. These ministries offer an opportunity to coordinate actions across a number of sectors, but Mr. McDaid said he had the perception that these ministries aren't doing as well as they could in terms of mental health and working across sectors. There is a need to work more with these ministries to address the barriers to working across sectors.

The challenges of working across ministries in Canada are similar to experiences in the European Union (EU) which McDaid described as "a strange mix of quasi-federal institutions and member states with different power and abilities, and mutual distrust". Perhaps there are lessons to be learned by examining experiences in the European Union. Seven or eight years ago, mental health wasn't on the agenda at all. But today, there's a keen awareness. In this kind of political environment, it is dangerous to move to a mandatory model. Rather, there is a need to work toward consensus and non-mandatory monitoring and implementation. It may also be valuable to think about the value of the partnership between the EU and the World Health Organization (WHO). This has been a useful relationship, particularly in helping countries endorse a mental health charter which includes discussion about implementing and monitoring MHP.

In terms of implementing and monitoring MHP and MIP, McDaid argued it is great to have leaders and bodies to do this but some groups at the national level lack the power to monitor performance at the provincial level. Thus, mechanisms to evaluate the extent to which governments are living up to policy directions are vital to implementation. When nothing else works, shaming can be effective (e.g., WHO rating of countries). Media attention can be a strong lever for change. In short, mechanisms for reporting on changes resulting from MHP and MIP policy can be a powerful tool.

A final powerful approach described by McDaid is the removal of politics from MHP. While acknowledging this can be challenging, he argued there is scope to achieve some public consensus among political parties about the value of mental health and mental health promotion. Establishment of common positions makes it more possible to move away from short term views and toward longer-term approaches that extend beyond electoral cycles.

Dr. Howard Chodos

Mental Health Commission of Canada

Dr. Chodos thanked the organizers and participants of the Think Tank and noted the Mental Health Commission of Canada was delighted to have been part of the discussions about mental health promotion and mental illness prevention. Many members of the Commission, including board members, senior staff, and members of various advisory committees participated in the Think Tank.

In response to one of the previous speakers, Dr. Chodos pointed out that the Mental Health Commission of Canada is one of those national organizations that have no jurisdiction over provincial ones, nor can it engage in the direct monitoring of governmental activity in the mental health field. This was a compromise struck in order to enable the creation of the Commission and it is a limitation that all will have to live with over the next ten years. He expressed hope, however, that it will be possible to craft some imaginative strategies to work around these limitations, including promoting grass-roots activity that will encourage governments to "do the right thing." He said that the role of the Commission in this process would be to act as a catalyst and to provide access to information needed to sustain a movement for change.

Dr. Chodos noted that mental health promotion (MHP) and mental illness prevention (MIP) are some of the most complicated areas to address in a national mental health strategy. The philosophical and theoretical underpinnings, and the notions of flourishing and languishing, for example, are not simple matters to be resolved at a stroke of a pen. Many concrete suggestions had been put forward over the course of the day, he said, but it was not possible to respond to them that afternoon. However, he said that the Commission would carefully consider the full range of input from the Think Tank.

The MHCC is barely more than a year old, said Dr. Chodos. It is and will remain a small organization with a specific mandate that that initially comprised three key initiatives – facilitating the development of a national mental health strategy, conducting a ten-year anti-stigma and discrimination initiative and developing a national knowledge exchange centre. Since then, the government has seen fit to give the Commission an opportunity to develop research demonstration projects on homelessness and mental health. These projects are currently underway and there is much excitement and enthusiasm toward them.

The Commission's mandate does not involve service delivery. "But is the Commission committed to mental health promotion and mental illness prevention?", Dr. Chodos asked. "Unequivocally, yes it is", he said. The Commission has formulated its priority principally as improving the health and social outcomes of people living with mental health problems and illnesses, but it is convinced this is unattainable without attending to MHP and MIP.

Dr. Chodos further explained that the Commission is also in the process of developing a national mental health strategy that advocates a recovery orientation for people living with mental illness. Recovery is not "business as usual" with respect to treatment. It is rooted in the promotion of the best mental health and quality of life possible for people living with mental health problems and illnesses, and emphasizes many of the same principles and dimensions as MHP. This will provide one avenue for integrating MHP and MIP in all the Commission's work.

In terms of developing the national mental health strategy, the Commission is on the eve of issuing a "framework" document that outlines goals for a transformed mental health system and for engaging people across the country in discussion about what such a system should look like. This process will begin later in 2008 and into early winter, 2009. The target for completion of the strategy is the spring of 2011. The framework contains a specific goal aimed at enhancing MHP and MIP activities, as well as encouraging the development of a comprehensive approach to mental health and mental illness.

Dr. Chodos noted, "In anything we do, the target we aim for is to be just inside the outer edge of political feasibility," that is, to push for as much change as can actually be accomplished. The goal, he said, is to transform the way the mental health system works and the way that Canadians view mental health and mental illness.

It has been a very encouraging first year for the Commission, with support expressed by stakeholders across the country and across governments. The Commission will continue to act as a catalyst and to collaborate with others in all its activities. Integral to success, Dr. Chodos concluded, is that we all work together to stimulate a broad social movement centred on promoting mental health for all – for those living with mental health problems and illnesses as well as for those who are not – and keeping mental health issue out of the shadows forever.

CLOSING REMARKS AND NEXT STEPS

Following the discussants' remarks and comments by Think Tank participants, Peter Coleridge, Co-Chair of the Pan-Canadian Steering Committee observed that while there is the Mental Health Commission of Canada, there is also the Public Health Agency of Canada and other national and provincial organizations. "We're all in this together", he said, and it is important to understand the constraints and opportunities experienced by each organization. Based on the background paper, the discussions, and insights from the four discussants, Coleridge said, "It's not about what we need to do. We know what needs to be done. It's about the *how*. It's about doing our work differently". What's needed is to engage more with other partners, to understand the language of other sectors, and within that, to reach consensus and compromise to get to the desired change and set some priorities and targets. The Pan-Canadian Steering Committee looks forward to working with Think Tank participants in these efforts, he said. The Committee will now focus on the "next steps" to move mental health promotion and mental illness prevention policy forward in Canada.

Pan-Canadian Steering Committee co-chair, Beth Evans closed the meeting by thanking participants and Steering Committee members for their contributions. She encouraged all to stay well and to go forward, to flourish, and to be champions for mental health promotion.

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 Board - Alberta Health Services

Members (in alphabetical order)

Mary Bartram/Howard Chodos
Mental Health Commission of Canada

Marion Cooper
Winnipeg Regional Health Authority

Jayson Doll
Ontario Ministry of Health Promotion

Lori Idlout
Embrace Life Council

Suzanne Jackson
Centre for Health Promotion, University of Toronto

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: THINK TANK AGENDA

National Think Tank on Mental Health Promotion and Mental Illness Prevention
November 4, 2008

AGENDA

8:00 a.m.	*Refreshments and Registration*	
9:00 a.m.	*Welcome*	Beth Evans Peter Coleridge
9:05 a.m.	*National Mental Health Strategy Update*	Madeleine Dion-Stout
9:15 a.m.	*Toward Flourishing for All*	Dr. Suzanne Jackson
9:35 a.m.	*Break into Small Groups/Refreshments*	
9:45 a.m.	*Breakout Discussion Groups*	

1. How can we work collaboratively across different levels and sectors and segments of society to promote mental health and prevent mental illness?
2. Which policy model is best for effective mental health promotion and mental illness prevention in Canada?
3. What are the key elements to be included in a MHP & MIP policy for Canada?

11:45 a.m. – 12:45 a.m. *Lunch Break*

12:45 p.m.	*Report Back on Three Questions*	
1:15 p.m.	*Breakout Discussion Groups (continued)*	

4. How can we support effective implementation at different levels and Establish the infrastructure and resources needed?
5. How do we evaluate MHP & MIP policy impact to ensure accountability for mental health?

3:00 p.m. – 3:30 p.m. *Break*

3:30 p.m.	*Report Back and Response from Discussants*	Dr. Corey Keyes Dr. Margaret Barry David McDaid Dr. Howard Chodos
4:40 p.m.	*Closing Remarks*	Peter Coleridge, Beth Evans