

*Literature Review*

*Prepared for the Ministry of Health and Long-Term Care*

*Healthy Communities Theme Group*

# **Promoting Mental Health and Well-Being**

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## Contacts for the Literature Review

Michelle Gold

Senior Director, Policy and Programs

Canadian Mental Health Association, Ontario

[mgold@ontario.cmha.ca](mailto:mgold@ontario.cmha.ca)

416-977-5580, ext 4151

Bob Gardner

Director of Policy and Research

Wellesley Institute

[bob@wellesleyinstitute.com](mailto:bob@wellesleyinstitute.com)

416-972-1010, ext 229

# Setting the Context

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## Momentum is Building

Canada enjoys a legacy of leadership in health promotion and there is no health promotion without mental health promotion. Increasing understanding that positive mental health affects us all, contributes to the growing momentum for mental health promotion around the world. Recent events and reports, supported by evidence, leadership and commitment, indicate that the time is right for action in Ontario to develop and implement new policies, as well as incorporate existing policies, which can promote mental health.

In particular, a number of recent events can be seen as milestones, which heighten momentum for Ontario. In conjunction with the 19<sup>th</sup> International Union for Health Promotion and Education Conference, 2007, a preconference symposia, “No Health Without Mental Health”, took place in Vancouver. This one day symposium convened international and Canadian researchers, policymakers and practitioners to increase worldwide collaboration and discussion in mental health promotion. The Ontario Ministry of Health Promotion participated on the planning committee and there was significant representation at the event from this province.

In November 2008, the Pan-Canadian Planning Committee for Mental Health Promotion and Mental Illness Prevention hosted an invitational Think Tank in Calgary to discuss mental health promotion and prevention strategies in jurisdictions outside of Canada. The deliberations of the Think Tank provided best advice on how mental health promotion and mental illness prevention policy formulation should proceed in Canada. Again, Ontario policymakers and non-governmental organizations were significantly represented at the event.

The Mental Health Commission of Canada has identified mental health promotion as a recommended strategic direction in their national mental health strategy, under development.

In Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health, Health Nexus, the Ontario Public Health Association and the Centre for Health Promotion at the University of Toronto have prepared a joint report, *Mental Health Promotion in Ontario: A Call for Action*, 2008, which provides a framework and recommendations for taking action to promote positive mental health in Ontario.

And in March 2009, the Clifford Beers Foundation hosted an international mental health promotion conference in Toronto, *Expanding Our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream*, with sponsorship from the Government of Ontario and significant planning support from Ontario non-governmental organizations.

## Mental Health

Since its inception in 1948, the World Health Organization (WHO) has included mental well-being in its definition of health as "... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2001). In 2004, the WHO conceptualized mental health as more than the absence of mental illness, but rather as "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.

Mental health – defined as maintaining a balance between the social, physical, spiritual, economic and mental aspects of one’s life – is as important as physical health in leading a productive and meaningful life. The 2006 release of *Out of the Shadows at Last*, Canada’s first national report on mental health and mental illness (Kirby & Keon, 2006), validated what both the World Health Organization and Public Health Agency of Canada recognize - there is no health without mental health.

Canadian definitions of mental health, grounded in the international literature include:

Mental health is... "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) the achievement of individual and collective goals consistent with justice ; and, the attainment and preservation of conditions of fundamental equality. (GermAnn & Ardiles, 2008a).

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. Produced through dynamic interactions between individuals, groups and the broader environment, mental health is the foundation of well-being and effective functioning for individuals, families, communities and societies. (GermAnn & Ardiles, 2008a)

Mental health then, is considered a resource created through our interactions with the world around us, and influenced by many societal, cultural, economic and political (structural) factors that extend beyond the control of individuals. These structural factors increase or decrease opportunities for individuals, organizations, communities and populations to be healthy .

## Equity

There has also been growing interest and commitment from the Ministry of Health and Long-Term Care (MOHLTC) and many Local Health Integration Networks (LHINs) in prioritizing health equity within the overall transformation of the provincial health system.

In a strategic framework developed for the Toronto Central LHIN, the Wellesley Institute defined health disparities or inequities as differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage. This definition identifies the problem that policies will try to solve; and it's also tied to widely accepted notions of fairness and social justice. Equity in health has been similarly defined as the absence of systematic disparities in health between social groups who have different levels of underlying social advantage/ disadvantage – i.e., that occupy different positions in a social hierarchy (Braveman & Gruskin, 2003).

This definition is also meant to be comprehensive. One of the critical trends – and challenges to policy makers in Ontario -- is the significant diversity of the population. Taking diversity into account means ensuring that the different needs and preferences of diverse communities are always analyzed, and that inequitable access, treatment and outcomes by race, country of origin, sexual orientation or any other line of discrimination and oppression is challenged and eliminated. Diversity issues are always an essential component of equity analysis and action. (Gardner, 2008).

Because the bases of health inequity are systemic and avoidable, health disparities are open to policy intervention. The overall goal of health equity strategy is to reduce or eliminate socially and institutionally structured health inequalities and differential outcomes. A positive and forward-looking vision of health equity is ensuring equal opportunities for good health for all. The impact of achieving this goal would extend far beyond enhancing individual and collective well being, but would also contribute to overall social cohesion, shared values of fairness and equality, economic productivity, and community strength and resilience.

Although the two terms are often confused, equity is not the same as equality. The key differences between equity and equality are that equity focuses on the distribution of resources among specific populations, whereas equality looks at whether differences exist or not. Equity is value-laden, whereas equality is not. Equity implies that some health inequalities are avoidable and unjust or unfair (Lettner, 2008) and have roots in a social justice orientation (WHO, 2008).

Definitions represent different paradigms and belief systems, which have important consequences for how interventions are conceptualized, measured and targeted, and how resources are distributed (Braveman & Gruskin, 2003). A biomedical orientation to health for example, has its roots in individualism and people's ability to control the factors that determine their health. Such an orientation over-emphasizes the role of the individual and usually neglects the wider social context which informs and shapes their "choices" (Raphael, 2004). From a mental health perspective, this

can lead to greater investments in individualistically-oriented therapies and solutions, which can represent a “disembodied psychology” that separates what goes on inside people’s heads from social structure and context (Friedli, 2009) .

The problem health equity strategies are trying to solve is pervasive disparities in health outcomes or status. Self-rated or reported health is seen as a reliable indicator of overall health and sense of well-being (Bierman et al, 2009). It is particularly significant in an analysis of mental health because positive mental health implies just such an overall sense of personal well-being. The percentage of adults in Ontario who report their health as only fair or poor increased as income decreased, reflecting an overall social gradient in health. The proportion of low income adults aged 25-64 who reported their health as fair or poor is about four times that for those in the highest income quartile.

Similar data is available for self-reported mental health, and it shows a similar social gradient. Low income men over 25 were five times as likely, and low income women three times as likely as those in the highest income quartile to report their mental health as fair or poor. Ontario data is also available for adults who had a high probability of a major depression: there was an income gradient in the percentage of women who had probable depression, with twice as many low income as high income(Bierman et al, 2009).

## **Social Determinants of Health**

The WHO recognizes that “by far the greatest share of health problems (are) attributable to broad social conditions.” (WHO, 2007) It describes the fundamental conditions for both physical and mental health as the social determinants of health (SDOH). These are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. Lack of equitable access to SDOH is associated with health inequities - the unfair and avoidable differences in health status seen within and between countries. According to the WHO, poverty, relative deprivation and social exclusion have a major impact on health and premature death, and the chances of living in poverty are loaded heavily against some population groups.

The Public Health Agency of Canada has identified twelve key determinants of health: income and social status, employment, education, social environments, physical environments, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowment, gender and culture, based on the original report of the Federal, Provincial and Territorial Advisory Committee on Population Health(1999).

It is unequal access to these social and economic determinants of health that underlies pervasive disparities in health outcomes and opportunities. Different socio-economic positions confer

different degrees of command over the resources which shape good health. Socio-economic position, along with ethnicity and gender, has been identified as a “fundamental cause” of health as they affect multiple disease outcomes through multiple mechanisms” (Link & Phelan, 1995; cited in Graham, 2007).

Poor mental health is consistently associated with unemployment, less education, low income or material standard of living, as well as poor physical health and adverse life events. Lone parents, those with physical illnesses and the unemployed make up 20% of the population, but these three groups contribute 36% of all those with neurotic disorders, 39% of those with a limiting disorder and 51% of those with disabling mental disorders (Friedli, 2009). In a recent Ontario study, people on social assistance had nearly four times higher rates of mood disorders than the non-poor and the working poor, while the working poor had worse self-reported health and mental health and higher rates of considering and attempting suicide compared to the non-poor group (Lightman, 2009).

A wide body of research indicates that economic insecurity, higher unemployment, less autonomy within jobs, more unpleasant or dangerous working conditions and less rewarding work are associated with poorer mental and physical health (WHO, 2008). The insecurity and anxiety associated with precarious work (i.e., non-fixed term temporary contracts, being employed with no contract, and part-time work) has a significant impact on worker’s physical and mental health (de Wolf, 2008a; Lightman, 2009).

Conditions of work have also been shown to affect health and health equity, with adverse conditions being disproportionately concentrated in lower-status occupations. Stress at work is associated with a 50% excess risk of coronary heart disease (itself positively associated with depression) and there is consistent evidence that high job demand, low control and effort-reward imbalance are risk factors for mental and physical health problems (WHO, 2008).

Recent research has shown that social and economic inequality more generally has far-reaching consequences on health. Not only does inequality undermine the social glue which underpins cohesive societies (i.e., trust, social capital), but it is associated with higher levels of mental illness. A recent analysis of international data found that rates of mental illness were higher in countries with greater inequalities. For example, an analysis of UNICEF data on children’s well-being found that adolescent pregnancy, violence, poor educational performance, mental illness and imprisonment rates were all higher in more unequal countries and in more unequal states in the USA (Wilkinson & Pickett, 2009). These analyses emphasize the social-psychological implications of social and economic inequality; that increased inequality is associated with less trust and with increased anxiety and stress. These critical elements of mental health and well-being are seen to be a crucial pathway through which inequality shapes poorer health along the social gradient.

The relationship between social determinants and health is not direct and one-way, but complex, cumulative and dynamic. Overall social and economic inequality, and specific conditions such as

poor housing, education, income and living conditions, have a negative impact on health, and there is a clear gradient in which health opportunities and outcomes become worse the lower down the social hierarchy. At the same time, however, poor health can contribute to lower paying and less secure positions within the labour market, lower educational achievements and more limited overall opportunities for social mobility. In these ways, poorer health can reinforce the social and economic inequality associated with poorer health in the first place. This relationship is interactive and cumulative over people's lives. (Graham, 2007; Wilkinson & Pickett, 2009).

Many researchers have emphasized the importance of a life-course approach to analyzing the impact of the social determinants of health over peoples' lifetimes (Graham, 2007). Considerable research highlights the importance of early years development for subsequent health, especially mental health. Disadvantage in early life makes an important contribution to poor health in adulthood; emotional and behavioural problems are both an important cause of disability in childhood and predict poor health in later life, even after controlling for adult socio-economic status (Friedli, 2009).

## **Healthy Communities**

The social determinants of health influence the health of individuals, communities and jurisdictions as a whole. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve their aspirations, satisfy needs, and cope with the environment (Institute for Research on Public Policy, 2003). Building healthy, supportive and accepting communities – where living and working conditions are safe, stimulating and satisfying – is an integral component of any health promotion strategy. It recognizes that changing patterns of life, work and leisure have a significant impact on health. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential (WHO, 1986).

People can only achieve their fullest potential when they are able to take control of those things which determine their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Engaging communities in identifying and directing health matters at a local level provides people with a sense of ownership and control of their own destinies. (WHO, 1986)

Strengthening community actions is another central approach to building healthy communities which has the two-fold benefit of identifying local needs and capacities from a bottom-up perspective to inform priority setting and decision making processes while also empowering communities to contribute to solutions that draw on their existing human and material resources (WHO, 1986).

Bradford has reviewed the growing body of research demonstrating that “place matters”, affecting the quality of life for all citizens and the prosperity of nations (CPRN, 2005). The attention now being paid to localities reflects the fact that many of today’s policy challenges are resistant to sectoral interventions designed and delivered from above by governments departments.

Place-based approaches seek to improve the social, cultural, economic and/or physical environment within a defined boundary, in order to improve overall health, including mental health; and reduce the differences in health among the people living within that area. Place-based approaches use the setting of a local area in which to carry out health promotion activities. (VicHealth, 2008) The four principles underlying a “place-based approach” include: tapping local knowledge (e.g., lived experience of residents, action research of community organizations), finding the right policy mix (combining universal policies and targeted programs), governing through collaboration (developing horizontal and vertical government partnerships) and recognizing local government and providing them capacity to inform public policy and serve as an optimal access point for citizen input (CPRN, 2005).

This model is asset-based since it emphasizes finding and supporting local strengths. Its solutions are tailored to the specific needs of each community, and it encourages community-building amongst local residents. As the body of knowledge on the relationship between place and health increases, the need to consider place as a key factor in the development of health policies and programs becomes more obvious, particularly for community-level interventions (CPRN, 2005).

Place-based policies are currently being used in the City of Toronto to address the needs of its 13 priority neighbourhoods. The work of the Strong Neighbourhoods Task force, established in 2004, led to a strategy that allows disadvantaged neighbourhoods to find ways of improving the use of existing resources and local knowledge helps identify program and policy barriers. This approach seeks to engage residents in the needs identification and priority setting processes so that they can participate with other partners in deciding how best to meet their needs. The very process of involving residents in making decisions and planning strategies to achieve better health is a clear example of mental health promotion in action. This approach empowers community members to take ownership and control of their own life and health. (CPRN, 2005)

Place-based approaches have gained international attention in the last decade in Britain, United States, and the European Union for their experimentation with community-based urban revitalization. Canada has not made much progress toward this collaborative place-based policy framework, though there are lessons to be learned from current initiatives underway in the City of Toronto.

While minimal research has been conducted on place-based approaches in rural Canadian settings, the Rural Development Institute at the University of Brandon (Manitoba) believes this approach has great merit in rural communities and is congruent with their Community Health Action Model.

Further research in rural communities is warranted specific to placed-based approaches and generally to health and mental health promotion interventions (Rural Research Institute, 2007).

## Positive Mental Health and Well-Being

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Positive mental health has been described by Keyes (Keyes, 2007a; 2007b) as “flourishing”. “Not only are flourishing individuals free of mental illness, they are also filled with emotional vitality and are functioning positively in the private and social realms of their lives.” (Keyes & Haidt, 2003). Keyes considers mental health and mental illness as separate concepts. In this context, the mental health continuum moves from the optimal mental health, flourishing, to the absence of mental health – described as “languishing”. Those who are languishing are neither mentally ill nor mentally healthy efforts but rather described as if “running on empty” (Keyes, 2003). Flourishing, situated on the other end of this continuum of mental health, is associated with emotional, psychological and social well-being. Curing or preventing illness will therefore not guarantee a mentally healthy population. Mental health and mental illness co-exist and efforts must be made to prevent mental illness/disorder and promote mental health and well-being.

Several key aspects of mental health are repeatedly identified in the literature:

- Mental health is the presence of something positive
- Poor mental health is a risk factor for poor physical health, and vice versa
- Mental health is distinct from mental illness
- The absence of mental illness should not be misunderstood as mental health
- Mental health is the result of the dynamic interactions between individuals, groups, communities and the population as a whole
- The complexity of the state of mental health necessitates varied actions at many levels and in numerous settings to improve mental health
- Mental health is determined by social, economic and environmental factors
- Mental health can be improved through the collective action of society – mental health is everybody’s business (GermAnn & Ardiles, 2008a).

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## Promoting Mental Health

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The WHO's *Ottawa Charter for Health Promotion* (WHO, 1986) describes health as a resource and health promotion as a responsibility for all, not only the health sector. It places health on the agenda of all policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion requires working across sectors, government ministries and levels of government as well as longer time frames to assess effectiveness. Commitments to health promotion and health for all were confirmed by the updated *Bangkok Charter for Health Promotion* (WHO, 2005). The vulnerability of children and exclusion of marginalized, disabled and indigenous peoples were also noted.

The *Ottawa Charter* involves five key actions: creating supportive environments; developing personal skills, strengthening community actions, reorienting health services and building healthy public policy. These strategies are diverse but complementary approaches that share the common goal of ensuring equal opportunities and resources to the determinants of health to enable all people to achieve their fullest health potential.

Mental health promotion 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 (ed.), 1997). Moreover, mental health promotion, a multi-disciplinary field, focuses on the whole population and aims to enable and achieve positive mental health (Jane-Llopis, Barry, Hosman, & Patel, 2005).

An enabling process done by, with and for people (Hosman & Jane-Llopis, 1999), mental health promotion emphasizes strengths, assets, participatory and empowering processes that strengthen the capacities of individuals, organizations, communities and populations. Mental health promotion promotes well-being by enhancing access to mental health determinants, strengthening protective factors, and mitigating risk factors (Pape, 2006; Willinsky, 2001).

Like all health promotion, mental health promotion actions are intended to support mental health throughout the lifespan and in a range of settings including: home, school, workplace and community. Mental health promotion aims to achieve better mental health and well-being across populations by: focusing on improving the social, physical and economic environments that determine the mental health of populations and individuals (Keleher & Armstrong, 2006).

## Mental Health Promotion for People with Serious Mental Illness

Mental health can be enhanced regardless of a diagnosis of mental illness, and is fundamental to an understanding of how mental health promotion can be targeted to people with mental illness. Canada's foundational work as set out in *Mental Health for Canadians: Striking a Balance* (Epp, 1988) rejected the notion that mental health and mental illness were opposite endpoints on a single continuum by advancing a two-continuum model of mental health and mental illness. The two-continuum model asserts that mental health and mental illness reside on their own continua, with minimal and maximal degrees of mental health and mental illness represented at the ends of each of their respective continua. The Two Continuum Model framework is presented in Appendix 1.

The development of a definition of mental health without reference to mental illness, coupled with a two-continuum model of mental health and mental illness has helped to establish the justification for research, policy and programs *focusing on positive mental health independent of mental illness*. This has the potential to shift attention away from intra-individual characteristics for mental illness, which had dominated mental health research, to inter-individual and societal conditions (equity, social justice, housing, etc.) connected to positive mental health of populations.

The Canadian Mental Health Association's Framework for Support model for people with mental illness (Trainor, Pomeroy & Pape, 2004) presents the key message that formal mental health services, while important, are not the only resource to promote mental health and recovery. Equally important are a person's peers (self-help or consumer groups), family and friends, and generic community organizations and groups. In addition, a person's access to the 'fundamental elements of citizenship' (work, housing, education, and income) is critical.

The goal of mental health promotion for people with mental illness is to ensure that individuals have power, choice and control over their lives and mental health, and that their communities have the capacity to support recovery. For each of the five action areas for health promotion identified in the WHO's *Ottawa Charter*, there are associated strategies that can promote positive mental health and well-being in individuals with mental illness. These include fostering policies that support consumer participation, connecting with community to promote social networks and social ties, combating stigma, as well as having access and support to access education, gain employment, live in safe and affordable housing and having adequate income.

The tools which people with mental illness need in order to recover and maintain their mental health are not very different from the resources that anyone needs for positive mental health.

## Three Key Dimensions Influencing Positive Mental Health

Based on their comprehensive review of the evidence, Keleher and Armstrong (2006) identify social inclusion, freedom from discrimination and violence, and access to economic resources as key determinants of health contributing to mental health. In Ontario, the Canadian Mental Health Association Ontario, the Centre for Addiction and Mental Health, Health Nexus, the Ontario Public Health Association and the Centre for Health Promotion at the University of Toronto have endorsed these dimensions as essential targets for action in their recent report, "Mental Health Promotion in Ontario: A Call to Action" (CMHA, CAMH, Centre for Health Promotion UofT, Health Nexus, OPHA, 2008).

**Social inclusion** is protective of mental health. A socially inclusive society is one where all people feel valued, their differences are respected, and their basic needs are met so that they can live in dignity. Conversely, social exclusion is 'the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of the person into the community' (Cappo, 2002).

Social inclusion can be addressed at the individual level, such as the number and nature of a person's networks and social ties, their participation in community life and their access to basic entitlements. It can also be considered more broadly in terms of the extent of social cohesion, social connectedness, social ties, social networks and social, economic and human capital within a particular group, community or society.

Social capital is a related term that refers to the ways in which individuals, groups or communities' interactions provide access to information, resources and supports (PRI, 2005). Evidence links social capital to a wide range of the determinants of mental health including: poverty reduction, healthy aging, community development, the settlement of new immigrants, educational attainment in Aboriginal communities. (Policy Research Initiative, 2005).

Young people who do not have confiding relationships are between two and three times more likely to experience depressive symptoms than peers who report more confiding relationships (Glover, Burns, & Butler, 1998) There is growing evidence of correlations between social capital and aspects of mental health including: common mental illnesses (Pevalin, Intra-household differences in neighbourhood attachment and their associations with health., 2002) (Pevalin & Rose, 2002); happiness and well-being; self-reported mental health status depressive symptoms feelings of insecurity related to crime and psychological distress. Low levels of social capital have been correlated with poorer mental health, it does not buffer against the negative impact of structural economic factors on health or common mental illness (VicHealth, 2005)

Social inclusion serves as a protective factor for mental health. Strategies that foster social capital, such as, healthy aging, settlement of new immigrants and educational attainment all contribute to positive mental health. (Policy Research Initiative, 2005)

**Discrimination** refers to actions taken to exclude or treat others differently because of their age, race, ethnicity, gender, sexual orientation disability or social class. People can experience multiple forms of discrimination – direct, indirect, interpersonal and systemic (Kreiger, 1999). Systemic discrimination occurs when policies, practices, laws or regulations disadvantage a specific group. Racial discrimination has been found to be associated with low self-esteem and sense of control, psychological distress, major depression, anxiety disorder and other mental disorders and associated reductions in productivity . (VicHealth, 2007)

**Violence** is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, or deprivation (WHO, 1996). Discrimination and violence are often linked. Violence is often the vehicle through which discrimination is acted out. Violence can take many forms, including child abuse, neglect by parents, bullying, youth violence, violence by intimate partners, abuse of the elderly, sexual violence, self-directed violence and collective violence (Herrman, Saxena, & Moodie, 2005).

People who experience bullying are more likely to suffer depression and other psychosocial problems such as low self-esteem, poor self-concept, loneliness and anxiety . People who suffer physical violence as children are more likely to experience a number of problems as adults, including a lower sense of personal control, less emotional support and more negative interactions with family and friends. These factors in turn are associated with depressive symptoms in adulthood . Women who are exposed to violence are at greater risk of poor mental health (WHO, 2000). Intimate partner violence is responsible for 9% of the total disease burden in Victorian women aged 15–44, with anxiety and depression accounting for over 60% of this burden (VicHealth, 2004).

**Access to economic resources** such as housing, education, work and income, is strongly correlated with mental health because it impacts social connectedness and one's sense of competence and control, as well as socio-economic status. Such factors are known to both protect and promote mental health (Mulvihill, Mailoux & Atkin, 2001). People may experience economic hardship as a result of a variety of difficult life situations, such as divorce, death or job loss. The resulting lack of monetary resources creates not only low income, but poverty in other essential resources, such as housing, education and employment.

Persons with low levels of education or outdated job skills often remain trapped in low-income jobs that perpetuate the cycle of poverty, further blocking their access to the resources they need to provide for themselves. Higher levels of educational attainment create an advantage in acquiring better employment opportunities in today's workforce. Better employment opportunities in turn

lead to higher income, which significantly lowers the risk of poverty. When quality of life is compromise due to lack of stabilizing resources, depression and anxiety often follow this route of stress and strain. (Eaton & Muntaner, 1999)

Poverty also affects children's mental health. Poor families are oftentimes consumed with acquiring resources to meet their basic needs. These conditions are associated with distress in the household, thereby impacting children's emotional and behavioural well-being (Sobolewski & Amato, 2005). Poverty reduces opportunities to foster children's social competence and educational attainment, which are predisposing factors for employability and subsequent earned income (Evans, 2004). These factors can create conditions that can perpetuate chronic poverty across family generations.

Economic participation is enhanced by strategies that support life skills and social inclusion, and address systemic inequities. Investing in strategies and supports that improve access to economic resources and remedy the inequalities experienced by disadvantaged or marginalized populations can significantly increase economic participation and promote positive mental health.

## Strategies to Address the Three Key Dimensions

Recognizing the complexity of the discussion on effectiveness and evidence in health promotion (Bodstein, 2007), detailed reviews of evidence-based strategies and programs which support the key dimensions of mental health, across the life span, to populations at-risk and in various setting are available in a number of publications and reports, and therefore are not duplicated in this report. In particular, we recommend the following resources:

- Canadian Institute for Health Information. Improving the Health of Canadians: Exploring Positive Mental Health. Ottawa, 2009. Available online at [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=PG\\_1492\\_E&cw\\_topic=1492&cw\\_rel=AR\\_1730\\_E](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1492_E&cw_topic=1492&cw_rel=AR_1730_E)
- Canadian Mental Health Association Ontario, Centre for Addiction and Mental Health, Centre for Health Promotion University of Toronto, Health Nexus, Ontario Public Health Association. Mental Health Promotion for Ontario: A Call to Action. November 2008. Available online at [http://www.ontario.cmha.ca/admin\\_ver2/maps/mental\\_health\\_promotion\\_in\\_ontario\\_2008.pdf](http://www.ontario.cmha.ca/admin_ver2/maps/mental_health_promotion_in_ontario_2008.pdf)
- Jane-Llopis E, Barry M, Hosman C, Patel V. Mental health promotion works: a review. Promotion and Education. The evidence of mental health promotion effectiveness: strategies for action. Special Supplement, 2005. Available online at [http://www.iuhpe.org/upload/File/PE\\_MH\\_05.pdf](http://www.iuhpe.org/upload/File/PE_MH_05.pdf)
- Keleher, H & Armstrong, R. Evidence-based mental health promotion resource. Report for the Department of Human Services and VicHealth, Melbourne, 2005. Available online at [http://www.health.vic.gov.au/healthpromotion/downloads/mental\\_health\\_resource.pdf](http://www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf)

## Customizing Strategies for Those At-Risk

People in low-income or other disadvantaged circumstances bear a disproportionate burden of mental and other illnesses. However, there is evidence that general health promotion programs tend to be taken up by the more educated and affluent, with the unintended consequence of widening health disparities in access to services (VicHealth, 2008). This highlights the importance of customizing and adapting mental and other health promotion programs to the specific needs and situations of vulnerable communities.

### Community-based Programs

Community-based delivery of health and mental health promotion services is seen to be one crucial and effective direction. The UK Department of Health (2001) highlighted a range of evidence-based mental health promotion interventions in different settings to assist practitioners in understanding what works at different levels and in a range of settings. For example, the *Community Mothers Programme* in Ireland and the United Kingdom provides support to first-time socially disadvantaged mothers in rearing their children up to 1 year of age and has had important and far-reaching health and social and economic impacts (for example, increased immunization rates, better dietary intake, improved psychological health, increased rates of mothers reading to their children, etc.; Llopis, Barry, Hosman & Patel, 2005).

Community arts projects hold promise in achieving positive mental health outcomes (Friedli, 2001); for example, a Community University Research Alliance demonstration project, the Newcomer Youth Theatre in Waterloo, helps diverse newcomer youth to build their confidence self-awareness and empowerment through theatre and creative expression. Preliminary findings have shown that students involved in the project have displayed resilience and enthusiasm, and have developed a bond that has been a positive and empowering experience (Community University Research Alliance).

Peer health ambassador type programs have also shown great promise in helping disadvantaged populations make their way through the health system and in developing and delivering culturally relevant health promotion outreach and services. A number of programs developed by Toronto-based Community Health Centres have involved training and supporting lay members of particular ethno-cultural communities or neighbourhoods working as peer health promotion or outreach workers or as brokers to help patients navigate the health system (Lettner, 2008).

### Culturally Appropriate Programs

Effective mental health promotion takes account of the varying needs and perspectives of an increasingly diverse society. The notion of culturally competent care goes beyond translation and interpretation (important though these services are) to engaging with the communities at all stages of program design, delivery and evaluation (Agic, 2004) so that interventions are rooted in an understanding of the community's cultural and history. In order to be effective and responsive to

the needs of a pluralistic society principles must demonstrate cultural safety, encouraging service providers, regardless of their cultural background, to communicate and practice in a way that takes into account the social, political, linguistic and spiritual realities of the people with whom they are working ( Mental Health Commission of Canada, 2009). This is particularly important for communities who have been traditionally marginalized (e.g., First Nations, Inuit and Métis) and/or who are disadvantaged (racialized communities, new immigrants; Patychuk & Seskar-Hencic, 2008; Access Alliance, 2009), who are at greater risk of mental health problems.

## **Addressing Equity in the Health System to Promote Mental Health**

Many of the most important forces producing health disparities are far beyond the health care system, and much of the solution to health disparities lies in macro social and economic policy, policy collaboration and coordination across governments, and cross-sectoral partnerships on the ground. Nonetheless, it is in poor and unequal health – and ending up sicker in the health system needing care -- that the effects of this wider social and economic inequality are felt. A great deal can be done within the health system to address the harsh impact of overall disparities and enhance the well being of even the most disadvantaged. Experience from leading jurisdictions that have developed comprehensive health equity strategies and action plans highlights the key mechanisms and components needed (Gardner, 2009).

### **Targets**

All jurisdictions with comprehensive equity strategies include targets. England is the leading jurisdiction in setting clear targets, monitoring and reporting progress against the identified targets, and adjusting policy and programs in response (Department of Health, 2009). Among its indicators are self-reported health and prevalence of major depressions. Equity outcome targets that could be adapted for disparities in mental health and well-being include reducing the differentials in self-reported mental health and major depression by gender, income, ethno-cultural background, immigration status or other social-economic variable by a certain percentage by a certain date. Mental health promotion activity targets could be increasing the proportion of specified vulnerable populations who participate in mental health promotion programs by a certain date.

### **Equity Planning Tools**

Effective tools have been developed to help operationalize equity . These have included equity lenses, that can be quickly applied to potential programs and issues to assess their equity implications, or health equity impact assessments, which analyze more deeply the potential impact of programs or initiatives on disadvantaged populations and how program utilization and impact is affected by wider social determinant-type factors.

More specifically, mental health impact assessments – “to “assess the potential impact of any new policy on the mental well-being of the population before its introduction, and evaluate its results afterwards” (WHO Ministerial Conference on Mental Health, 2005; page 4) have been recently identified in Europe as part of mental health action plans. They have been used in jurisdictions like the UK to support policy-makers, planners and people delivering programs and services which have the potential to improve the mental well-being of communities (Coggins, Cooke, Friedli, Nicholls, Scott-Samuel & Stansfield, 2007).

Victoria Health Promotion Foundation (2008) developed and is piloting a framework to provide a “lens” by which to incorporate equity into planning. It includes three dimensions of inequality of access, opportunity and outcomes. The following adapts this framework to mental health (adapting material from an Ontario Ministry of Health Promotion presentation (2009)):

- *inequality of access* – such as language, accessibility, cost and other barriers to mental health services, and mental health services that are not culturally appropriate for the target population;
- *inequality of opportunity* – barriers to the social, geographic and economic resources necessary to achieve and maintain good mental health, such as levels of education and literacy; income; personal safety and security; and social inclusion;
- *inequality of impacts and outcomes* – assessing differences in mental health status between groups in order to allocate resources to the more vulnerable, such as Aboriginals, some new immigrant populations, etc.

One of the challenges is to collect and adapt the variety of tools available. An important initiative is being undertaken by Scadding Court, a multi-service agency located in downtown Toronto, and the Centre for Addictions and Mental Health, to develop an on-line equity toolkit and interactive website (Gardner, 2009).

### **System and Performance Management**

Equity also needs to be incorporated into routine performance management and accountability processes, and into the dense web of financial incentives that drive day-to-day work (Gardner, 2008). For example, Toronto Central and other LHINs have required all hospitals to develop health equity plans, with the expectation that this will be extended to all service providers.

### **Strategically Target Investments and Interventions for Greatest Equity Impact**

Those leading jurisdictions with comprehensive health equity strategies combine overall broad policy directions with specific programs and services targeted to the most health disadvantaged communities (Gardner, 2009). Targeting resources and services where they will have the greatest impact on reducing critical access barriers and improving the services and health of those facing the

harshest disparities requires good local research and information to be able to analyze which populations are most in need and will benefit most from targeted interventions, and what barriers and problems are creating the disparities. Community-based research has been particularly effective at providing rich and nuanced understandings of the mental health needs of disadvantaged populations (de Wolff, 2008b).

### **Create innovative knowledge management strategy**

A great deal of innovative front-line service delivery across the country addresses the needs of health disadvantaged communities (Gardner, 2009). However, little systematic research has been done on the outcomes of such equity-driven service provision, the key 'success factors' that underlie the most dynamic programs, and the policy and institutional frameworks needed to enable local front-line innovation and equity-focused initiatives. There is a pressing need for more community-based needs assessments, service evaluation and outcomes research to focus on local equity interventions and innovation.

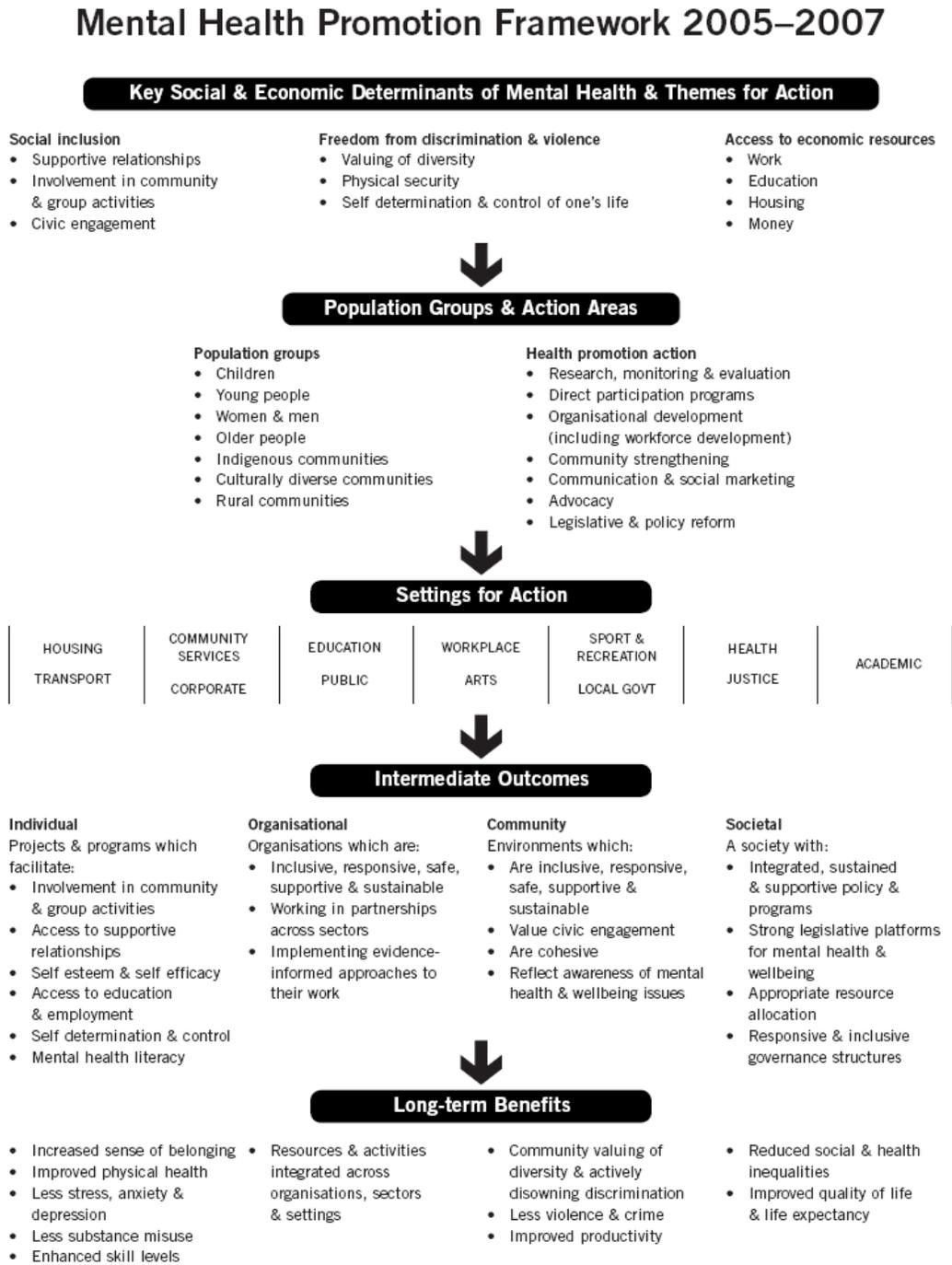
Similarly, the great potential of this wealth of front-line innovation is not currently being realized because there are few ways to systematically share 'best practices' and 'lessons learned' among service providers. The policy challenge here is how to systematically identify promising innovations, evaluate and assess their potential beyond their local circumstances, share information widely on lessons learned, and scale up promising initiatives where appropriate to create a permanent cycle and culture of front-line innovation on equity. Essentially, the challenge is to create an innovation knowledge management strategy.

## **An Integrated Conceptual Framework for Mental Health Promotion**

The World Health Organization's approach to mental health promotion is fundamentally concerned with action to address the full range of potentially modifiable determinants of health. A combination of factors influence mental health. The confluence of social, economic and environmental conditions together with an individual's heredity, knowledge and skills ultimately determines a person's health outcomes. These determinants include those related to the actions of individuals, such as health behaviours and lifestyles, as well as factors such as income, social status, education, employment, working conditions, access to appropriate health services and the physical environment (VicHealth, 1999).

Australia's VicHealth Mental Health Promotion Framework offers a conceptual framework of how jurisdictions can take action to promote mental health, incorporating the elements of key dimensions, target populations (including those at-risk and across the lifespan), actions, settings and outcomes [Diagram 1]. It begins with the three key determinants of mental health previously identified: social inclusion, freedom from discrimination and violence; and access to economic resources. Actions to address these three determinants are directed to specified populations, incorporating a variety of actions. These defined actions, while more specific than the five action areas identified in the Ottawa Charter, are conceptually similar. These actions are then directed to a variety of possible settings to achieve intermediate outcomes. It is expected that through achieving these intermediate outcomes, longer-term outcomes including positive mental health will result.

Diagram 1. The State of Victoria, Australia’s Mental Health Promotion Framework



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# Developing Public Policy

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## **Making the Case**

Moodie and Jenkins (2005) argue that every government, local, provincial or national, whether in developing, transitional or developed countries, can benefit from the inclusion of mental health promotion as a integral part of overall health, social and economic policies.

Good mental health contributes to society and has a positive effect on overall productivity. Positive mental health contributes to human, social and economic capital, while poor mental health unequally affects those who are socially and economically disadvantaged, and directly contributes to poverty . Poor mental health also contributes to poor physical health (Herrman & Jane- Llopis, 2005).

Mental health promotion is usually considered the responsibility of the health sector despite the fact that the health sector has little effect on the determinants of mental health. Other sectors that are more influential in affecting the social determinants of mental health, such as education, housing, sports and justice, are often unaware of the effect that they have on mental health. They should be encouraged to expand their health promoting work, or at minimum, consider the impact of their policies on mental health. (Moodie & Jenkins, 2005)

Further, to get mental health promotion into policy it is important to have a good understanding of the current policy environment (context, needs, demands, existing policies) and develop an overall statement of mission, goals and targets, strategic plans and readily understood and comprehensive frameworks. Such frameworks should be addressed who are major or potentially major promoters of mental health.

## **‘Mental Health is Everybody’s Business’**

Intersectoral collaboration, considered key to mental health promotion (Herman, 2005), requires policies and programs within and across sectors that influence the determinants of mental health across settings and individuals’ lifespan. The literature is clear that mental health promotion depends on intersectoral collaboration.

Whole-of-government approaches are intended to engage government and non-governmental organizations to collectively address challenging public issues which straddle traditional silos and boundaries. Whole-of-government approaches have been applied in many Commonwealth countries, including Canada, in order to support government reform processes. These endeavours are oftentimes associated with cabinet committees, inter-ministerial councils, and intersectoral task forces. They work across portfolio boundaries to achieve a shared goal and an integrated response to

a public issue. Strategies may address policy development, program management or service delivery. Whole-of-government approaches are envisioned to create synergies by bringing together diverse stakeholders and make better use of scarce resources, thereby offering public goods and services that more accessible and better coordinated.

A recent review of whole-of-government initiatives in North America, New Zealand, Australia and the United Kingdom, has identified a number of lessons learned. Firstly, whole-of-government strategies need to be thought of as long-term, as it takes time to broaden one's understanding of issues in order to set common goals, jointly act, create common standards and shared systems. More so, whole-of-government initiatives should receive the same status as distinct policy, departmental or sector initiatives, in order to create the necessary recognition and incentives to avoid re-focusing on intra-organizational vertical accountability. In addition, changes in organizational culture need to occur, in order to build a common ethic and cohesive culture in which to collectively work. Lastly, these approaches will have the greatest likelihood of success when they engage other actors and institutions ; that is, in municipalities, non-governmental organizations and grass root community actors, as whole-of-government approaches need cooperative effort and cannot easily be imposed from the top down. (Christensen & Laegreid, 2007)

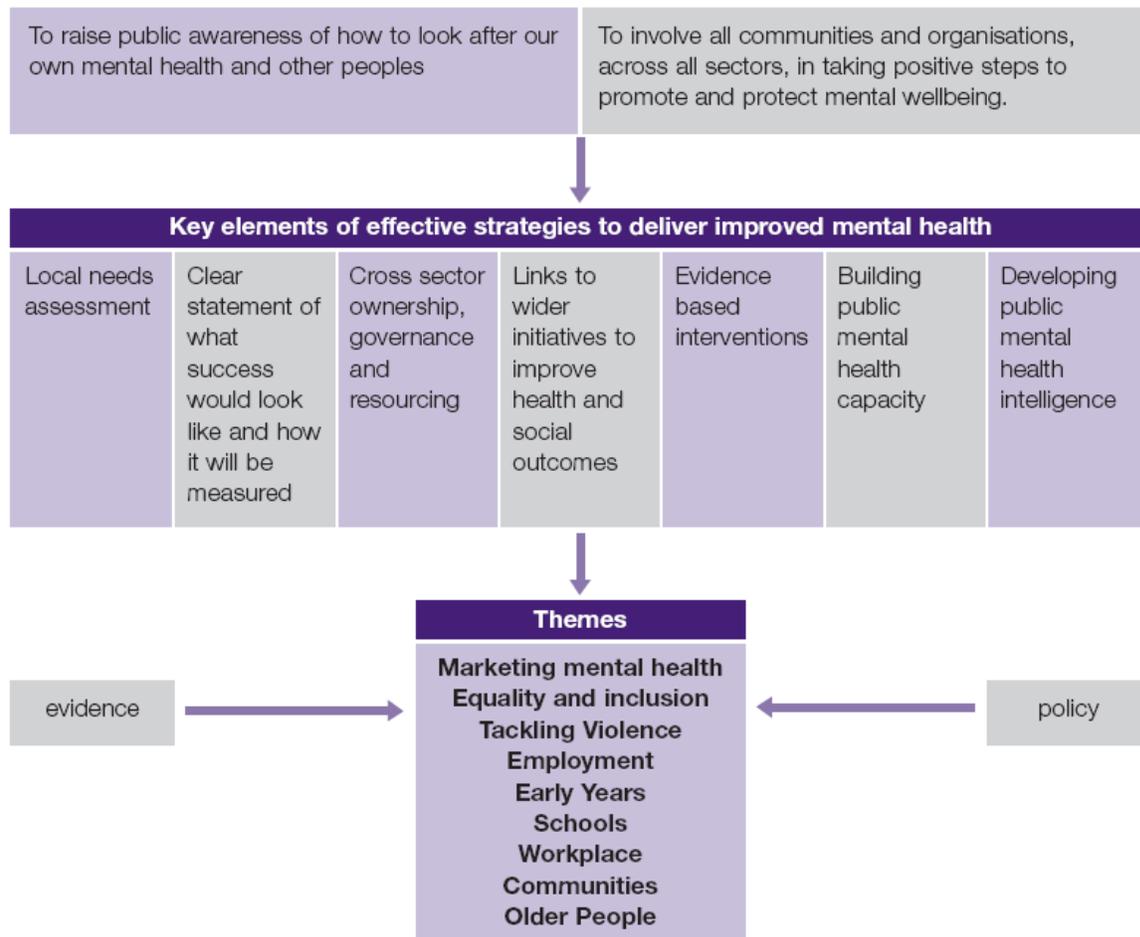
Public policies in all sectors influence the determinants of health, even if their primary objective is to achieve something else (Kickbusch & McCann, 2008) For example, policies designed to improve public housing or early years services, or to reduce social and economic inequities, will help create the supportive environment or conditions that promote mental and physical health.

"The Adelaide Recommendations on Healthy Public Policy", (WHO, 1988), call for a political commitment to health by all sectors. Policy-makers working at all levels (international, national, regional and local) were urged to consider the impact of their decisions on health. The "health in all policies" approach "aims to address complex health challenges through an integrated policy response across portfolio boundaries". (Kickbusch & McCann, 2008) At the more recent South Australia Government's "Health in All Policies" Conference, 2007, core principles were articulated to guide the adopted approach. In Kickbusch et al (2008), the core principles recognize: the *value of health* for the wellbeing of all citizens; that *health is an outcome of a wide range of factors*; that *all government policies* can have positive or negative impacts on the determinants of health; that the *impacts of health determinants are not equally experienced* by all population groups; that efforts to improve the health of the population will require *sustainable* actions; that the most pressing health challenges require *long-term policy and budgetary commitment*; that the indicators of success are *long-term*; the need to *consult with citizens* to link policy changes with wider social and cultural changes and that *potential for partnerships* for policy implementation between government at all levels and others is necessary to bring about change.

### Action Framework

“Making It Possible” (Care Services Improvement Partnership and National Institute for Mental Health in England, 2005) sets out a framework for action to promote mental health for individuals, organizations and communities, as part of England’s National Service Framework for Mental Health. In its implementation framework, the multiple actions necessary to develop a mental health promotion strategy are identified, as illustrated in Diagram 2. This framework details the key steps: needs assessments, clear vision and indicators; multi-sectoral collaboration; links with wider initiatives; evidence-based interventions, knowledge development and capacity building.

Diagram 2. Multiple Planning Steps Are Necessary to Take Action for Positive Mental Health



Source: National Mental Health Development Unit.  
 Making It possible: improving mental health and wellbeing in England. 2005

An additional key action recommended by Canadian experts on mental health promotion is to identify and map existing policies and initiatives that support mental health in order to identify strengths and gaps that suggest routes for future action (GermAnn & Ardiles, Towards Flourishing for All... Policy for Canadians, 2009a).

## **Mental Health Promotion Policy Options: International Approaches**

A National Mental Health Promotion and Mental Illness Prevention Think Tank, was held in Calgary, Alberta on November 4, 2008 to discuss considerations for mental health promotion and mental illness prevention policy development and implementation in Canada. In preparation for that meeting the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention commissioned a policy background which included a comprehensive review of international mental health promotion policies (GermAnn & Ardiles, 2009a).

GermAnn and Ardiles' (2009a) review of mental health promotion and mental illness prevention policies in international jurisdictions focused on England, Scotland, Ireland, New Zealand, Australia and the European Union. The findings were organized around five key policy processes: collaborative action for policy development, policy design, content, implementation and monitoring and evaluation. Four distinct policy models were identified along with their respective strengths and limitations:

### ***Mental health promotion integrated into broad mental health policy within general health sector***

Strengths: enables a seamless approach; integrated MHP/MIP across all dimensions of mental health services. Limitations: risks sublimation of MHP/MIP to demands for service delivery and bio-medical approach.

### ***Distinct mental health promotion policy situated in the general health sector***

Strengths: enables focus on MHP/MIP. Limitations: without strong linkages to other sectors and policies, may contribute to "silos" and risk insufficient resourcing, if not a priority in the sector.

### ***Distinct mental health promotion policy situated within public health***

Strengths: strong potential for synergistic action with general health promotion and public health activities, including action on health determinants; ability to draw on public health expertise and capacity in mental health promotion and funding not competing with mental illness services and treatment. Limitations: may impede integration of MHP & MIP into the mental health treatment system

***Mental health promotion incorporated into broad social policy***

Strengths: more likely that determinants of mental health will be addressed. Limitations: Potential loss of focus on mental health; may suffer against competing priorities and difficult to measure mental health promotion outcomes.

The review found that mental health promotion policies were most successful in the presence of strong mental health polices, strong leadership, government commitment, allocation of sufficient resources, multi-sector collaboration, a focus on evidence-based practice and a workforce with specific training in mental health promotion and mental illness prevention. Challenges included: achieving a vision of positive mental health, acquiring a common vocabulary, the integration of mental health promotion and mental illness prevention, insufficient resources, the challenges of cultural and linguistic diversity, cross-sector collaboration and the regression to policies that primarily focus on treatment and service delivery

**Lessons Learned**

A number of lessons learned from the review of the mental health policies in international jurisdictions, identified by GermAnn & Ardiles are key to the development of effective mental health promotion and mental illness prevention polices, frameworks and strategies. They include:

**★ Mental Health Promotion as a Process**

Successful mental health promotion policies and programs embody key mental health promotion principles and practices such as: collaboration, civic engagement, multi-sectoral actions at the systemic, community and individual levels, in a variety of settings throughout the policy process (development, content, implementation and evaluation).

**★ Multi-sectoral Collaboration/Engagement**

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.

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

### ★ **Ownership of Mental Health Promotion 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. 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 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. New Zealand's *Building on Strengths* MHP policy was developed through an extensive two-year consultation with key stakeholders (Raeburn, personal communication, June 2008 as cited by GermAnn & Ardiles 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 ... 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).

### ★ **Flexible language**

A key element of success in these efforts has been a flexible approach to language about mental health, positive mental health, mental health promotion and mental illness prevention, with the recognition that that other sectors may use different words – emotional well-being, for example – that are similar in meaning to positive mental health.

### ★ **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, mental health promotion policy development.

★ **Integrating mental health promotion & mental illness prevention policy into public health policy**

Mental health promotion experts widely advocate for integration of mental health promotion and mental illness prevention into public health. 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.

★ **Integrating mental health promotion & mental illness prevention policy into broader social policies**

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.”

★ **Overview of successful mental health promotion and mental illness prevention strategies**

Success in international jurisdictions was enabled by national- level mental health policies, in the presence of strong leadership, allocation of sufficient resources, multi-sector collaboration, a focus on evidence based practices and practice based evidence and specific training in mental health promotion and mental illness prevention.

## **Recommendations from the 2008 Calgary Think Tank**

The Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention convened a 2008 national invitational Think Tank on Mental Health Promotion and Mental Illness Prevention, following up on momentum which has built in Canada as a result of the 2005 Mental Health Promotion Summer Institute at the University of Toronto, and the mental health preconference symposium held prior to the 2007 International Union of Health Promotion and Education Conference in Vancouver. The purpose of the think tank was to engage key decision-makers, experienced practitioners and researchers in dialogue about mental health promotion and mental illness prevention policy development in Canada .

The key recommendations of the proceedings, as set out below, are intended to inform and guide the development of mental health promotion and mental illness prevention policy development in local, provincial and national level jurisdictions in Canada (GermAnn & Ardiles, 2009a).

### ***Comprehensive mental health policy***

Build upon a mental health promotion framework that reflects positive mental health for all; addresses all levels of need, across the lifespan, values social justice, resilience, self-determination, strengths and empowerment; and works collaboratively across sectors to address the social determinants of health.

### ***A clear single point of accountability and sustained leadership***

In collaboration with potential partners, identify a single point of accountability for policy, in the presence of collaborative leadership. Ensure there are sufficient dedicated resources to support policy implementation.

### ***Involvement of multiple sectors and stakeholders***

Engage all relevant sectors and stakeholders in the development and implementation of a comprehensive policy. People with mental illness, those at risk for mental illness, groups dealing with the social determinants of health as well as Aboriginal people must be engaged in the processes.

### ***Common understanding***

Develop support for a vision of positive mental health by engaging the public in processes that promote social inclusion, combat stigma, address the social determinants of health and enhance mental health literacy.

***Build on strengths***

Map existing policies and program that support positive mental health to identify strengths and gaps for future action.

**A strong research, knowledge and data base**

Enhance the mental health promotion knowledge base by supporting new areas of research, such as participatory action research, evaluation of innovative practices and economic evaluation. In addition, build on existing initiatives, utilizing information collected by Statistics Canada and the Canadian Institute for Health Information, to develop relevant indicators to monitor progress in achieving positive mental health.



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## Appendix 1 : Two-Continuum Model

*Mental Health for Canadians: Striking a Balance* (Epp, 1988) rejected the traditional notion that mental health and mental illness were opposite endpoints on a single continuum by advancing a two-continuum model of mental health and mental disorder. The two-continuum model asserts that mental health and mental illness reside on their own continua.

The development of a definition of mental health without reference to mental illness, coupled with a two-continuum model of mental health and mental illness has helped to establish the justification for research, policy and programs focusing on positive mental health independent of mental illness. This has the potential to shift attention away from intra-individual characteristics of mental illness to social and societal conditions (equity, social justice, housing, etc.) connected to positive mental health of populations.

The diagram below illustrates that one’s mental health can be enhanced regardless of a mental illness diagnosis, and is fundamental to an understanding of how mental health promotion can be targeted to people with mental illness.

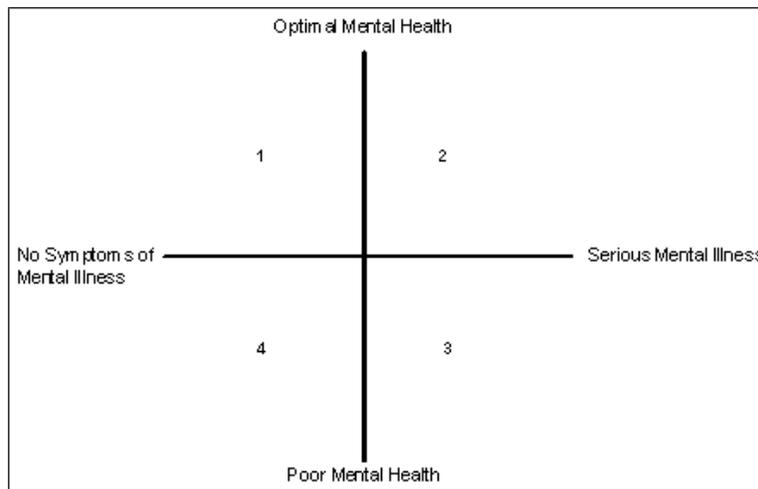
Quadrant 1: people with good mental health and no mental illness.

Quadrant 2: people have symptoms of mental illness but still experience good mental health, i.e., they are coping, have social support, feel empowered, are able to participate in activities that are important to them and are reporting good quality of life.

Quadrant 3: people have symptoms of mental illness as well as experiencing poor mental health as a result of the impact of mediating factors, such as being unemployed, having poor housing or being homeless, no social support or low income.

Quadrant 4: people are experiencing poor mental health or difficulty coping as a result of situational factors, although they do not have symptoms of mental illness.

The Two Continuum Model demonstrates that one's mental health can be enhanced regardless of a mental illness diagnosis, and is fundamental to an understanding of how mental health promotion can be targeted to people with mental illness.



Two Continuum Model