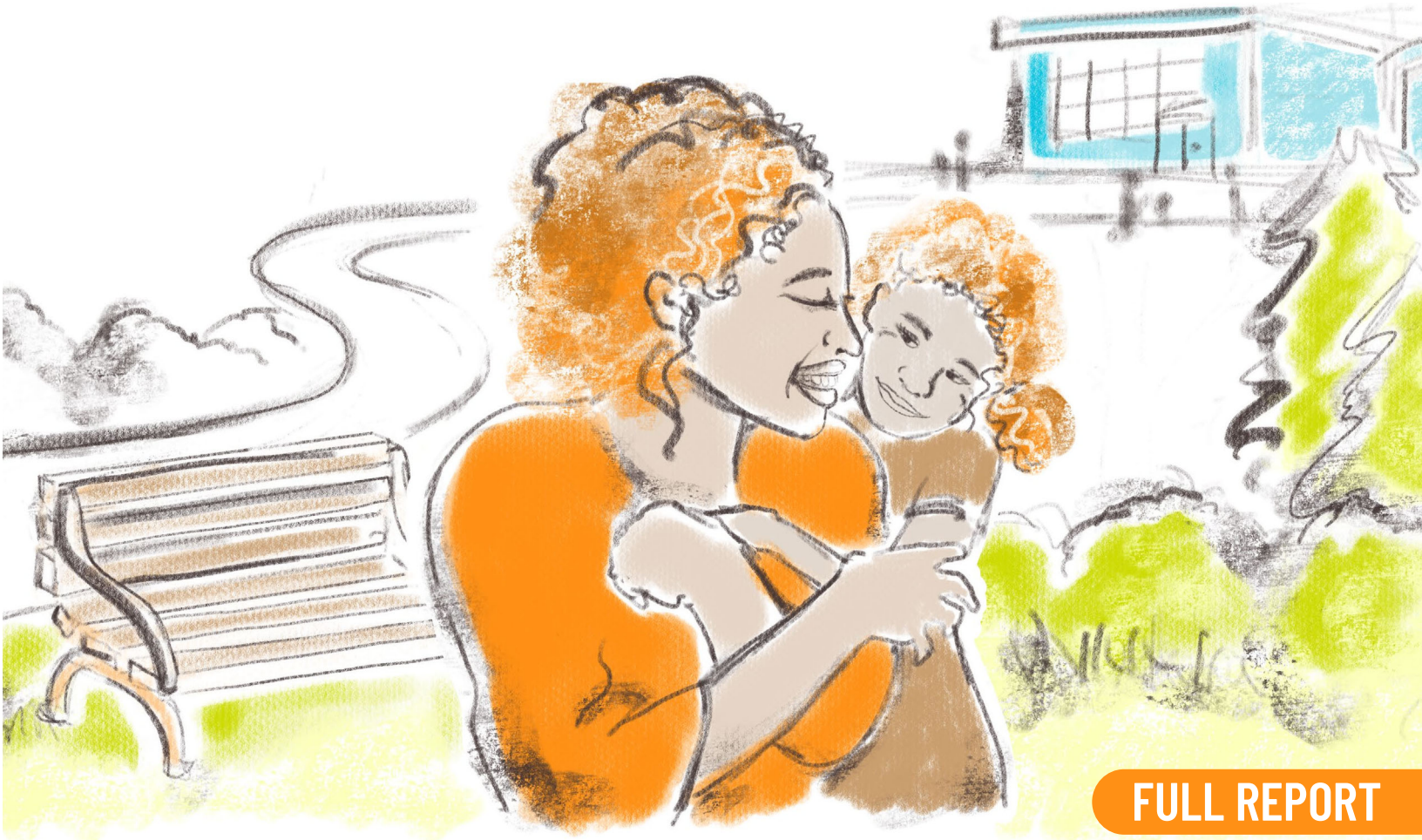
Cohesive, Collaborative, Collective:
Advancing Mental Health Promotion in Canada



FULL REPORT

MAY 2019

Canadian Mental Health Association
Mental health for all

100 years of community

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Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province and one territory, CMHA provides advocacy and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

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INTRODUCTION

The improvement of mental health is increasingly becoming a priority across Canada, as one in five people in Canada personally experiences a mental health problem or mental illness in any given year.[1]

Public and private expenditures for mental health services and supports continue to increase. The Mental Health Commission of Canada (MHCC) estimates that the direct annual cost attributable to mental health problems and mental illness—health care, relevant social services, income supports—is at least $42 billion.[2] By contrast, total direct costs for cancer care in Canada, which includes hospital care, was in 2012 estimated at $7.5 billion,[3] while direct costs for heart failure are estimated at $2.8 billion per year.[4] These costs parallel those in peer jurisdictions such as England and at the global level: the World Health Organization (WHO) estimates that mental illnesses account for 30% of non-fatal disease burden worldwide and 10% of overall disease burden, including death and disability.[5] It has been estimated that mental illness will cost the global economy $16 trillion between 2010 and 2030.[6] Although expenditures to treat and support people who experience mental health problems and mental illness represent a considerable and increasing economic cost, and mental illness directly impacts 20% of people in Canada, experts indicate that countries are not investing adequately in mental health:[7] in Canada, only 7.2% of publicly funded health care spending is allocated toward mental health.[8]

This evidence of the considerable and growing cost of treating mental health problems and mental illness[i] has led to increased attention to early intervention and upstream approaches. Since the 1990s, mental health researchers and practitioners have advocated for a move beyond the prevention and treatment of "disorder."[9] While most efforts to support mental health focus on symptoms management and/or the treatment of addiction or illness, mental health promotion (MHP) takes a proactive approach, focusing on the early and continuous development of positive mental health.

Mental health promotion cultivates positive mental health in individuals and communities through a combination of targeted and broad interventions across the life course, in communities, workplaces, and schools.[10] It is distinct from (but intersects with) prevention, which aims to reduce symptoms and rates of mental illness.[11] MHP initiatives build individual skills, supportive environments, and community resilience, all of which are recognized as integral to the development of mentally healthy societies.[12] If implemented effectively, evaluated

i Throughout this document, references to mental health and illness are inclusive of substance-related issues, including addictions. Similarly, references to mental health and illness services include the full continuum of substance and addiction-related services, even when the latter are not explicitly named.

regularly, and sustained over the long term, MHP has the potential to reduce public and private sector expenditure on mental health care and treatment. What makes mental health promotion unique is its attentiveness to health and social systems as well as its focus on individual and population health.[13]

MHP efforts are numerous and fall into several broad categories: information dissemination, anti-stigma/discrimination reduction campaigns, health risk appraisals or wellness assessments, lifestyle and behavioural change, and environmental control. They may be universal (developed for an entire group/population), selective (targeted at those identified as at risk) or indicated (developed for those expressing early signs or symptoms of mental health problems).[14] MHP efforts aim to develop positive mental health among all people, whether they live with or without a mental illness. Although, as noted above, 1 in 5 people in Canada will experience mental illness or a mental health problem in any given year, 5 in 5 people in Canada have mental health that ought to be protected and promoted. In this way, MHP aligns with the stepped care model, which maintains that low-intensity interventions in community settings (including schools and workplaces) are more cost-effective and can prevent individuals from needing more cost- and time-intensive intervention. The stepped care model is premised upon a continuum of mental health promotion and mental illness prevention, in that it leverages universal, selective and indicated interventions available in community-based supports (see **Figure 1**).[15]

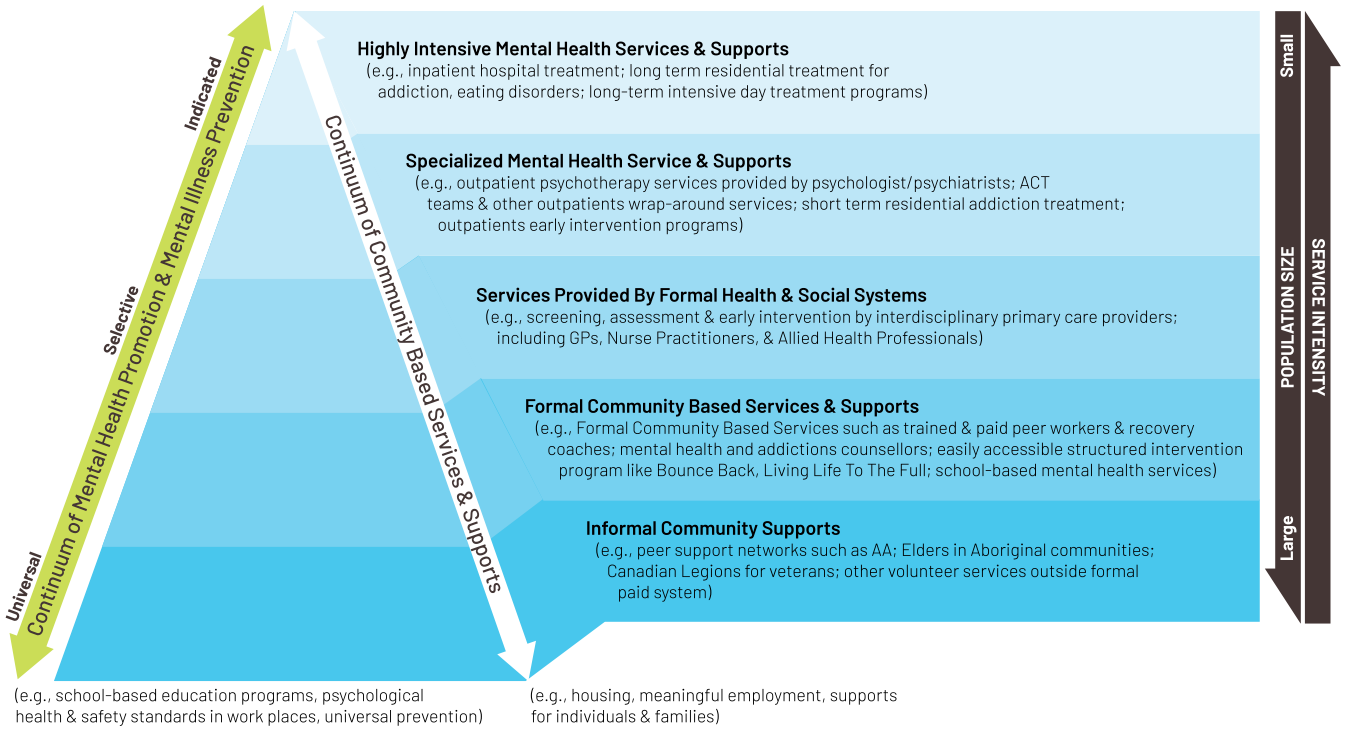


FIGURE 1. CMHA National Stepped Care Model
(Adapted from British Columbia Ministry of Health Services and Ministry of Children and Family Development, 2010).

When directed at individuals, mental health promotion focuses on personal and social development and on life skills such as coping strategies, adaptability, help-seeking or communication skills, self-efficacy, resiliency, parenting, and other life skills. Individual-level interventions work to reduce risk factors and increase protective factors, improving mental health and behavioural outcomes, regardless of their relationship with mental illness. Communities are also productive spaces for the implementation of MHP because they foster social connection and integration—key social determinants of mental health. Community-based efforts target a range of populations—new parents and seniors, for example—and often work towards supporting community groups and organizations that offer mentally healthy organizations and towards incorporating others into MHP initiatives to encourage people's participation.[16] Also, given that 60% of people in Canada participate in the workforce, and the strong evidence showing that workplace-based interventions for physical health and well-being are effective, workplaces have also been identified as appropriate settings for MHP.[17] In recent years, organizations have come to recognize the importance of maximizing employee mental (and physical) health in order to improve worker productivity, reduce absenteeism and presenteeism,[ii] meet legislative changes, and reduce health care costs.[18] Some forward-thinking organizations have begun to embrace cultural change with the intent to produce an organizational culture that promotes mental health and well-being.[19]

MHP is underpinned by several potential positive mental health outcomes, ranging from the individual level to the societal level: ability to enjoy life (e.g., sense of purpose/contribution) and hope for the future; ability to deal with life's challenges; emotional well-being; spiritual well-being; social connections; and respect for culture, equity, social justice and personal dignity.[20] These outcomes align with the Indigenous Wellness Framework, four directions that provide guidance for exploring the meaning of mental wellness within Indigenous communities: purpose in daily life, be it through education, employment, caregiving or other cultural pathways; hope for the future, as grounded in identity, Indigenous spirit, and unique Indigenous values; a sense of belonging and connectedness to family, community and culture; and, a sense of meaning and an understanding of connectedness to creation and history.[21] Mental health promotion programs and efforts are comparable to longstanding interventions that aim to promote and improve population health, including suicide prevention and the prevention of problematic substance use. MHP arose from a need for coordinated and organized programs to supplement individualized services and efforts aimed at mental illness prevention. MHP programs are informed by social-adaptive models for prevention and promotion, which recognize the importance of individual- and societal-level efforts to shift community and environmental conditions.[22]

Research on mental health promotion has proliferated in recent years and emphasizes the importance of a conceptual and practical distinction between mental illness *prevention* and mental health *promotion*, even though the two terms are often used interchangeably. Mental illness prevention interventions are typically implemented ahead of the

ii According to CMHA Ontario, presenteeism is "the action of employees coming to work despite having a sickness that justifies an absence and, as a consequence, they are performing their work under sub-optimal conditions." For more information see: https://tinyurl.com/y4vpxnr3

onset of a "clinical episode," and focus on reducing the "incidence, prevalence or seriousness of targeted mental health problems."[23] In contrast, interventions built on a foundation of mental health promotion endeavour to build long-term, positive mental health. For the purposes of this report, such a terminological distinction is important given that "making the case for promoting positive mental health involves demonstrating that these outcomes are not just the result of the absence of mental illness, but are due, wholly or in some degree, to aspects of positive mental health."[24]

The MHP framework also recognizes two important principles: first, that mental health and physical health are co-constitutive;[25] and second, that mental health and mental illness exist along a continuum. In the first instance, poor mental health is a risk factor for chronic physical conditions, people with serious mental health conditions are at high risk of experiencing chronic physical conditions, and people with chronic physical conditions are at risk of developing poor mental health.[26] In the second instance, MHP efforts are underpinned by Corey Keyes's "two continua" or complementary model of mental health, in which, "the absence of mental illness does not imply the presence of mental health, and the absence of mental health does not imply the presence of mental illness."[27] Keyes recognizes that focusing solely on mental illness is unlikely to positively influence the promotion of mental health, and that reducing the number of cases of mental illness in a society will not automatically result in a mentally healthier population. For Keyes, mental health efforts ought to focus on promoting "flourishing" as well as preventing illness.

Awareness of the potential and impact of mental health promotion activities and programming is growing in academic research, education systems, policy analysis and implementation, and advocacy. Federal and state-level governments in Canada,

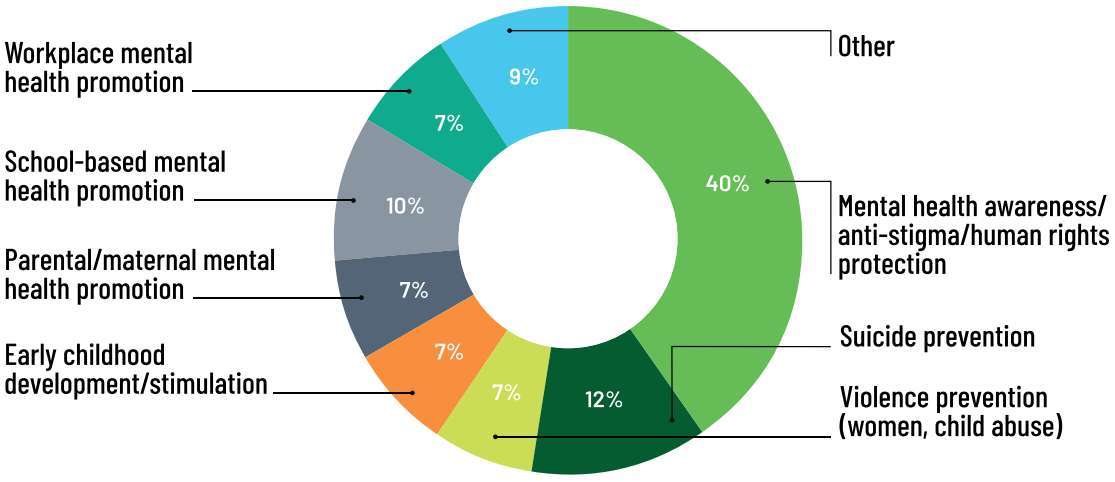


FIGURE 2. Mental Health Promotion and Prevention Programs: Main Type of Program
(Adapted from WHO Mental Health Atlas, 2017).

Australia and the United States (US) have pioneered efforts to develop national policies, strategies and programs that draw on the objectives and language of mental health promotion, particularly in government services and sectors (e.g., education).[iii] According to the WHO's report on the presence of stand-alone mental health policies and plans, mental health promotion is increasingly part of these efforts.[iv] The WHO's 2017 *Mental Health Atlas* reports that "123 countries…or 63% of all WHO Member States, have at least two functioning national, multisectoral mental health promotion and prevention programs" and that "out of almost 350 reported functioning programs, 40% were aimed at improving mental health literacy or combating stigma and 12% were aimed at suicide prevention."[28] A snapshot of the distribution of mental health promotion programs is presented below (see **Figure 2**).

Recent research offers compelling evidence for moving theory into practice, demonstrating that when effectively implemented, mental health promotion interventions support "lasting positive effects on a range of health and social outcomes."[29] Considering the increasing global disease burden, and monetary costs associated with mental illness, researchers recognize that treatment alone is unlikely to have a significant impact on escalating rates of mental illness.[30] This recognition has led to a focus on population mental health, and specifically on interventions that enable individuals to protect their mental health. Recent health economic evaluations suggest that investing in mental health promotion is cost-effective in the short- and long-term, as demonstrated through randomized control trials (RCTs) of MHP programs,[31] program evaluations,[32] and systematic reviews and meta-analyses.[33] In addition, recent policy analyses have undertaken cost-benefit and cost-effectiveness analyses of mental health promotion efforts.[34] These latter analyses focus on the impact that MHP can have on the economic costs of mental illness, or the potential economic return on investment of such interventions. This impact is possible because MHP emphasizes the entire community and addresses the social determinants of health, which are often linked to mental health problems and mental illness.[35]

However, mental health promotion programs have yet to see consistent, long-term and sustainable public expenditure such that they can be comprehensively implemented in schools, workplaces and communities.[36] As the WHO's *Atlas* finds, as depicted above, the majority of mental health promotion efforts are around awareness-building and consciousness raising; far fewer efforts comprise the settings-based programs that are needed to translate awareness into behaviour and systems change. Uncertainty about the long-term impact of mental health promotion may account for the still-limited political and fiscal investment, as may the limited appeal of long-term benefits in a cyclical political context.[37]

In a social context in which depression is now the leading cause of disability worldwide with[38] policies and programs that aim to promote mental health can no longer remain under-recognized facets of primary prevention—they urgently require increased recognition and adoption in order to anticipate or

iii Some notable examples include the Centre for School-based Mental Health (US), The Mental Health Education Integration Consortium (US), and the Centre for School Mental Health (Canada).
iv According to the WHO's *Mental Health Atlas*, 81% of responding countries, on average, reporting having a stand-alone mental health policy or plan in place.

ameliorate increases in demand for services. Limited attention, both in Canada and elsewhere, has been paid to the social impact and economic return on investment of mental health promotion programming and initiatives and subsequently to advocating for investment in such programming (alongside advocating for increased funding for mental health care services). With this in mind, the objective of this paper is to:

- Review, through consideration of academic and grey literature, the state of current research and policy on mental health promotion in Canada and in peer jurisdictions;
- Assess the current landscape of mental health promotion programming across the life course, in Canada and in peer jurisdictions;
- Examine the economic and social return on investment of programs and interventions that promote mental health, drawing on national and international analyses;
- Consider whether and how mental health promotion programming can align with the social determinants of health, and address emerging socio-economic challenges in Canada;
- Outline an evidence-informed policy response to mental health promotion planning, strategy development and implementation.

The motivation for this examination of MHP comes from our recent policy paper, *Mental Health in the Balance: Ending the Health Care Disparity in Canada*, in which the Canadian Mental Health Association (CMHA) calls for a national *Mental Health Parity Act* to bring mental health care into balance with physical care. In this paper, CMHA presented five strategies that, if included in such an *Act*, would ensure that mental health is valued proportionately and equitably within Canada's health care system.[39] An investment in mental health promotion, prevention and early intervention is recognized among these strategies, and the current paper aims in part to elaborate upon this strategy such that decision-makers can operationalize MHP in their communities, workplaces, agencies and governments.

RESEARCH QUESTIONS

The following questions guided this analysis:

- What is the current state of research and policy on mental health promotion, particularly mental health promotion programming? What settings are identified as most effective for the development and implementation of mental health promotion?
- What does the evidence indicate about the social impact and cost savings of mental health promotion programs and initiatives for individuals, clinical and community health care systems, social systems, education systems, and workplaces? Are the reported impacts and outcomes of mental health promotion programs consistent with the evidence base established in extant research?
- What research and policy analyses have been conducted to measure the rate of economic and/or social return on investment of mental health promotion programming, in terms of cost savings and impact, respectively?
- Can mental health promotion programming respond to anticipated social and economic trends that intersect with mental illness in Canada? If so, how?

DEFINING THE CHALLENGE

Current academic and policy analyses of mental health promotion demonstrate the positive impact and cost savings potential it offers; however, Canada's mental health promotion landscape requires strategic and social investment to streamline effort, measure impact and progress, and increase uptake. To get there, we need to build and mobilize a common understanding of MHP, focus programming efforts, and encourage coordination of effort by enhancing cross-sectoral collaboration.

THEORETICAL FRAMEWORK

This analysis takes an ecological approach to mental health promotion programming.[40]

In addition to psychological, biological and neurological factors, mental health and mental illness are determined by underlying individual, social, cultural, community, organizational, economic, and environmental factors.[41] Consequently, approaches to mental health promotion and the cultivation of positive mental health should, by extension, also account for these factors. Although mental health promotion efforts emerged from Keyes's two continua model, this model is limited as a framework for analysis because of its emphasis on the individual. In turn, it is further limited in its capacity to account for social and economic factors and not well positioned to examine mental health in collective/social arrangements.

By contrast, an ecological model provides a framework for acknowledging and understanding the interrelation between the individual, organizational and social determinants of mental health and the impact of mental illness (see **Table 1 below**). Mental health promotion experts, including researchers and policy makers, recommend the adoption of an ecological approach to guide analyses and measure effectiveness of MHP.[42]

Alongside protective and risk factors, the social determinants of health also influence mental health. These align with the factors outlined above, specifically at the structural and environmental level. Attention to the social determinants of health and the cultivation of healthy environments is integral to improving physical and mental health and supporting the prevention of mental illness.

LEVEL	PROTECTIVE FACTORS	RISK FACTORS
INDIVIDUAL (psychological make-up, behaviours and physical health)	**Cognition**: ability to problem solve, manage one's thoughts, learn from experience, tolerate life's unpredictability, adopt a flexible cognitive style; fluency of language of adopted country; high self-esteem and self-concept; connection to original culture (as relevant), etc. **Emotion**: feeling empowered; sense of control or efficacy; positive emotions; positive sense of self, etc. **Social**: good/appropriate social skills (communication, trusting, etc.); sense of belonging, etc. Resilience; good physical health; healthy behaviours, etc.	**Cognition**: weak problem-solving skills; inability to tolerate life's unpredictability; rigid cognitive style; negative temperament, etc. **Emotion**: low self-esteem; feeling a lack of control of one's life; negative emotions, etc. **Social**: isolation; weak social skills; exposure to violence, etc. Certain behaviours such as absence of physical activity, problematic substance use, poor physical health. Adverse life events, including adverse very early life experiences, also contribute, as does genetic vulnerability to mental illness.
FAMILY AND COMMUNITY	Strong emotional attachment; positive, warm, and supportive parent-child relationships throughout childhood and adolescence; secure and satisfying relationships; regular communication; high levels of social capital (including reciprocity, social cohesion, sense of belonging, and ability to participate), etc.	Poor attachment in childhood; lack of warm/affectionate parenting and positive relationships throughout childhood and adolescence; insecure or no relationships; isolation; low levels of social capital and belonging; social exclusion; inability to participate socially; domestic violence; separation from family; parental physical or mental illness, etc.
STRUCTURAL AND ENVIRONMENTAL	Socio-economic advantage (i.e., higher levels of education, good standards of living, including housing, income, good working conditions); economic security; freedom from discrimination and oppression; low social inequalities; legal recognition of rights; social inclusion; public safety; access to adequate transport; safe urban design and access to green spaces and recreation facilities, etc.	Socio-economic disadvantage (i.e., low education, low material standard of living, including inadequate housing, homelessness, unemployment, inadequate working conditions); economic insecurity and debt; social and cultural oppression, continued colonization and discrimination; war; migration; poverty and social inequalities; exclusion; neighbourhood violence and crime; lack of accessible or safe transport; poor urban design; lack of leisure areas, green spaces, etc.

TABLE 1. Social determinants of mental health in a population mental health framework.
(Adapted from Raphael, 2016; National Collaborating Centre for Healthy Public Policy, 2014; and Caring for Kids New to Canada (Canadian Paediatric Society, n.d.).)

For decades, health promotion and health population experts have emphasized the relevance of an ecological model to health care issues,[43] and have drawn on an ecological approach to better understand, for example, the impact of culture on women's health,[44] the effect of musculoskeletal disorders on office workers,[45] and violence against women with disabilities.[46]

An ecological approach is frequently employed in studies on and approaches to mental health.[47] In this context, this approach accounts for the micro (individual), meso (organizational and community) and macro (societal and environmental) level factors that influence a given phenomenon or individual experience. An ecological approach makes it possible to recognize that mental illnesses "should be considered as conditions of people always in transaction with social and environmental contexts."[48] The Public Health Agency of Canada (PHAC) recognizes that individual, familial, community and social factors all intersect with and influence positive mental health.[49] When applied to health, whether mental health or physical health, this model responds to the call for integrated action at the levels of individuals, communities and society, as outlined in landmark documents such as the Ottawa Charter for Health Promotion, as well as in the Jakarta Declaration and the Bangkok Charter.[50]

METHODOLOGY

To conduct this analysis, we examined peer-reviewed and grey literature that addresses the significant individual, organizational, and societal factors that inform the conceptualization of mental health promotion and the development of mental health promotion programming.

Using key words related to mental health promotion, prevention of mental illness, mental health promotion programming and related concepts such as anti-bullying, and suicide and violence prevention, we accessed academic databases that index relevant peer-reviewed and grey literature (Google Scholar, EBSCO, ProQuest, PsycINFO, Cochrane Library) as well as policy documents and guidelines from relevant institutes (e.g., Canadian Institute for Health Information, World Health Organization, TRIMBOS Institute (Netherlands), Institute for Clinical Evaluative Sciences (ICES), Mental Health Commission of Canada (MHCC), Institute for Health Economics (IHE)).

We focused on the collection and analysis of high-quality studies of mental health promotion programming in terms of design (e.g., randomized control trials (RCTs)). Yet, the limited number of such studies necessitated the inclusion of studies that offered reasonable and strong conclusions on mental health promotion (e.g., experimental studies, pre-test/post-test designs, evaluations). Because research on the economic return on investment (EROI) of mental health promotion is nascent, we also included studies that included social return on investment (SROI), even though these studies report benefits that are difficult to translate into practice and to replicate. In addition, we included and considered studies that employ health economic evaluation, which is adjacent to return on investment as this approach draws on cost-effectiveness and cost utility.

Following the literature review, we conducted an environmental scan. Environmental scans enable the consideration and examination of a wide range of data, which can identify strengths, commonalities, patterns, and gaps, and inform the development of recommendations for future changes and decision-making. Jurisdictions chosen for the scan were based on their membership in the OECD or G7. To ensure that the scan reflected relevant policies and programs, we focused on the settings identified in the literature as most relevant to mental health promotion: schools, workplaces, and community settings. To synthesize our findings, we drew on meta analyses, scoping reviews, and systematic literature reviews that have been conducted on mental health promotion. To supplement our findings, we hand-searched reference lists to identify additional sources that did not arise in our search results. We also considered toolkits, guides and programs to catalogue MHP efforts.

This research was informed by CMHA's Public Policy Working Group, which is composed of policy experts representing CMHA provincial branches, regions and divisions from across Canada, and in consultation with CMHA's National Council of Persons with Lived Experience (NCPLE), National Executive Team (NET) and National Board of Directors.

The evidence acknowledged in this paper provides a detailed but not comprehensive snapshot of action, research, and policies on mental health promotion. It focuses on mental health promotion programs across the life course, with a view towards highlighting the

current state of MHP, identifying program impacts and ongoing challenges, and assessing policy gaps and directions that should be addressed to strengthen the MHP landscape. In turn, there are likely numerous other policies and programs, such as poverty alleviation initiatives or school-based physical activity programming, that have been shown to have a positive impact on mental health but are beyond the scope of this project. In general, health promotion efforts have not been included in this analysis because even though these may be beneficial to mental health, they are not primarily implemented for this reason.

The evidence considered here is presented from a "life course" perspective, which enables an account of reality in which risks to mental health can emerge early in life and again at crucial transition points (e.g., from high school to college; adolescence to adulthood; work to retirement).[51] A life course perspective also enables us to recognize that while early intervention is critical, interventions in adulthood are also an integral part of mental health promotion.

RECOMMENDATIONS

Our review of academic literature, national and international public policy, toolkits and guiding documents on mental health promotion determined that mental health promotion offers social and economic return on investment and represents a promising landscape that demands greater investments to support its cohesion.

This would include: additional research investments to enhance the quality and longevity of available evidence; greater support for inclusive and effective programs and, an approach to strategy and policy that, at the national level, focuses on the principles of early prevention and intervention that undergird MHP. The aim of our recommendations is to encourage sufficient investment in infrastructure to support the identification, implementation, and evaluation of high-quality, systems-based, culturally safe mental health promotion programming.

Our recommendations are below.

RECOMMENDATION

1 Revive and implement a national-level Mental Health Promotion Strategy that contains formal policy and a clear mandate, including quality standards for the development, administration and implementation of mental health promotion programs, and the development of a mental-health-based analysis that will, on a prospective and retrospective basis, encourage consideration of the mental health implications of all federal policies and programs.

In Canada, recent funding agreements between federal, provincial, and territorial governments have prioritized increased funding for mental health and addictions care, including commitments to enhance community-based treatment.[52] CMHA has continually called for such funding in its advocacy and policy efforts,[53] and recognizes that investment is essential to address unmet needs and to reduce barriers to access. However, deliberate strategic focus at the federal level on upstream measures is also vital to meet long-term objectives for population health improvements as well as to provide high-quality health care and reach fiscal sustainability across budgets.

Population health improvements are met through initiatives and programs to improve nutrition, enhance physical activity levels, increase access to medical care, improve sanitation, and provide safe drinking water. Yet, the health benefits that these initiatives and developments make possible have not been felt equally among communities in Canada. Much of Canada's population health and mental health problems are attributable to socioeconomic and environmental factors.[54] The "uneven distribution of accidents, stresses, environmental pollutants" and inequality (including stigmatization, which is addressed later) also influence the prevalence of mental health problems.[55] Many populations, including Indigenous and people of colour communities, people who live with mental illness, people with physical and/or intellectual disabilities, people who live in poverty, rural communities, street-involved and homeless populations, vulnerable youth, and older adults

continue to experience high and persistent levels of health inequity, especially mental health inequity.

In 1988, Health and Welfare Canada released the landmark report, *Mental Health for Canadians: Striking a Balance,* which is often recognized as a national mental health promotion strategy for Canada. This report presented for national-level consideration a broader, social, and positive understanding of mental health. Leveraging health promotion mechanisms, including self-care, mutual aid and healthy environments, as well as implementation strategies, including public participation, strong community health services, and healthy public policy, the report offered a series of guiding principles for the development, review and implementation of policies and programs for mental health promotion. These guiding principles are: equal rights for and enfranchisement of people who live with mental illness; bolstering volunteerism and peer support models; empowering people with lived experience and centering them in the decision-making process; generating partnerships between mental health professionals and communities; allocating resources to communities so they can build their capacity to promote mental health; bringing the best research and knowledge to bear on sector challenges; and coordinating policy between all stakeholders (public sector, business and industry, education, not-for-profit sector, and education).[56] Despite the forward-looking vision outlined in this document, it was not realized due to lack of investment in the implementation of its recommendations. Thirty years later, chronic underfunding and underresourcing remain a key barrier to fully realizing the promise of mental health promotion in Canada.

The 2005 Integrated Pan Canadian Healthy Living Strategy, which was released in 2005, included MHP among its priorities alongside obesity reduction, injury prevention, and reduction of health inequities. Although mental health promotion was subsequently integrated into national-level health promotion efforts, this work temporarily lost momentum as the Strategy has not reported since 2008. From there, in 2012, the Mental Health Commission of Canada released *Changing Directions, Changing Lives,* Canada's first mental health strategy. Although not a dedicated mental health promotion strategy, the report emphasizes the "promotion of mental health for the entire population and to the prevention of mental illness wherever possible" and that "we cannot afford to wait any longer to implement these programs as widely as possible."[57] *Changing Directions* emphasizes the growing and compelling evidence of the effectiveness of MHP and agrees with extant evidence that schools, communities/homes and workplaces are the most appropriate settings for mental health promotion. As the first strategic direction in the Strategy, four priorities for mental health promotion, alongside accompanying recommendations, are presented: **1)** increase awareness about how to promote mental health; **2)** increase the capacity for mental health promotion and early intervention for infants, children and youth; **3)** create mentally healthy workplaces; **4)** increase capacity for mental health promotion and early intervention for older adults.[58] The Strategy is highly attentive to how different aspects of health issues—promotion, prevention, treatment, and recovery—intersect with identity, social life, and human rights.[59]

Although *Changing Directions* made considerable strides with regard to advancing the case for mental health promotion in the Canadian context, it does not contain guidelines for implementing mental health promotion interventions/activities in the

priority settings that it identifies. Specifically, while each priority in the Strategy is accompanied by recommendations for increased support, the expansion of initiatives, and greater availability of programs, the Strategy does not contain an implementation strategy. In light of this, and as has been highlighted by other stakeholders and organizations, there remains a need in Canada for a formal, national MHP strategy.

A formal, up-to-date National Mental Health Promotion Strategy can address the mental health inequities attributable to socio-economic status, geographic location, social isolation and/or marginalization because it can leverage MHP to build opportunities for social integration, respect for difference, and the creation of safe and cohesive communities. Although efforts, as outline above, have been made over the past 30 years to develop a national-level strategy that, explicitly or implicitly, attends to mental health promotion in Canada, these strategies have not yet been fully implemented. It is time for Canada to revive and update available strategies to support the deliberate implementation of a National Mental Health Promotion Strategy that contains an accompanying funding commitment for implementation, evaluation, and translation to other policy contexts (e.g., justice).

In the past decade, attention to MHP has grown in policy and strategic development contexts across Canada. British Columbia's *Mental Health and Substance Use Strategy 2017-2020* recognizes promotion, prevention and early intervention as its three pillars.[60] Prevention and early intervention is the first strategic pillar of the Northwest Territories' *Mind and Spirit Mental Health and Addictions Strategic Framework*, 2016–2021,[61] and of PEI's *Mental Health and Addiction Strategy 2016–2026*.[62] Ontario's *Open Minds, Healthy Minds*, a 2011 mental health and addictions strategy, does not name MHP specifically, but outlines the importance of "healthy, resilient, inclusive communities" to mental health.[63] This was echoed in Ottawa Public Health's 2015–2018 Strategic Plan, *Building a Healthier Ottawa*. The Region of Waterloo, Ontario launched an MHP-specific report in 2016 entitled *Mental Health Promotion: Let's Start Speaking the Same Language,* which addresses the breadth of MHP, its intersection with the social determinants of health, and the importance of a clear understanding of MHP. Across Canada, mental health promotion and mental illness prevention are increasingly recognized as complementary and essential to the cultivation of resilient individuals and healthy communities.

Several of Canada's peer jurisdictions have developed national mental health promotion strategies, yet the implementation challenges that persist for Canadian strategies are recognizable in these contexts. For example, in 2002, New Zealand/Aotearoa released *Building on Strengths*, its national mental health promotion strategy, which established a platform for mental health improvement and outlined how mental health promotion can support health promotion and

policy priorities.[64] It focused on strengthening individual resiliency and coping, building community cohesiveness and safety, and leveraging partnerships to reduce structural and access barriers to mental health, including meaningful employment, education and appropriate housing. The Strategy served as a springboard for a number of initiatives, including employment programs that support youth with mental health problems, community-based environmental justice programs that address mental health, and support for Te Rau Ora, a Māori organization that provides programs that improve Māori health and well-being.[65] Despite this Strategy and other strategies, the New Zealand government's 2018 inquiry into mental health and addiction, *He Ara Oranga,* calls for a paradigm shift in mental health services and policy making.[66]

MHP has also been integrated into health policy in peer jurisdictions. Ireland's national mental health policy, *A Vision for Change,* sets out several recommendations for mental health reform in the country. It mandates that early intervention, through the provision of mental health, is paramount to preventing mental illness and integral to all levels of the mental health system.[67] *A Vision for Change* proposes that MHP programs be incorporated into all levels of health services, including mental health services, via designated health promotion officers.[68] Queensland, Australia's newly released *Shifting Minds* strategic plan includes the strengthening of mentally healthy environments through the expansion and development of community infrastructure that coordinates MHP.[69] Prevention and promotion efforts comprise the first of Sweden's priority areas in its national mental health strategy.[70] Denmark's mental health promotion efforts include home visits by public health visitors, including the identification of postnatal depression.[71] In Iceland, mental health promotion, namely building positive environments and anti-bullying efforts, is part of the country's health promotion efforts in schools and its mental health action plan.[72]

Despite the now decade-plus long development, implementation and evaluation of MHP, both in Canada and abroad, and the range of mental health strategies outlined above, experts in MHP still find that MHP has yet to be *systematically* implemented in the same way as physical health promotion interventions have.[73] This absence has been attributed to mental health and public health professionals not having "an easily understood and practical framework to facilitate implementation," in comparison to what exists for physical health.[74] It can also be attributable to the silo model, or the isolation of mental health services from physical health services and the isolation of services within the mental health care system, where information flow and coordination are challenging.[75]

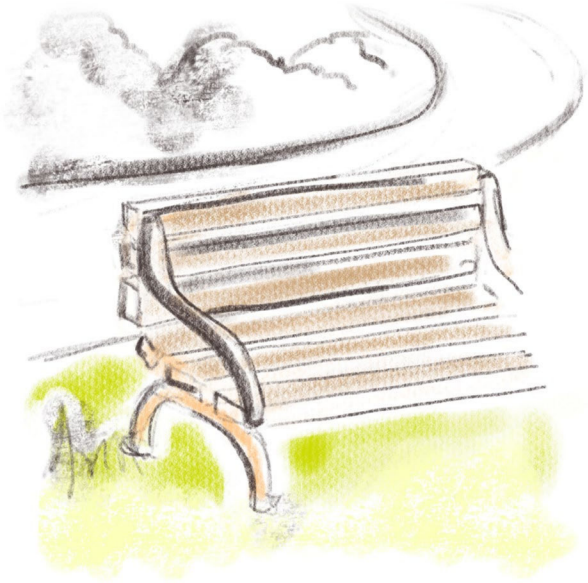
The revitalization of a formal, national-level Mental Health Promotion Strategy would establish a commitment to mental health promotion that is equivalent to Canada's commitment to and impact in health promotion. It could support the establishment of a common but inclusive understanding of mental health promotion, create guidelines for priority- and objective-setting, clearly establish that different populations have different needs, guide institutions on how to ensure programs account for diversity along the lines of race, sexuality, age, gender, ability, geography, access to technology, socioeconomic status, and education level, among others, generate implementation plans for models of program design and adaptation, and support consistent implementation and evaluation in diverse settings. Such a Strategy can rectify what the Canadian

Federation of Nurses' Unions (CFNU) in 2011 called a "patchwork of policies, approaches and supports with respect to mental health across the country."[76]

Although it may not be immediately apparent, the decisions that governments make, both in health care and also in other departments and ministries, have implications for mental health. Yet, decision-makers may not be comfortable considering or deliberating these implications if they do not have a set of procedures, tools, or a framework. In addition to reviving and revising a National Mental Health Promotion Strategy that provides clear direction for the implementation and evaluation of mental health promotion initiatives in Canada, such a Strategy must also contain provisions for the development of a framework for Mental Health Impact Assessment, which would apply a mental health lens to all policies. If developed to be retrospective and prospective, it could jointly examine the mental health impact of extant policy and predict the impact of future policy changes on people's mental health and well-being. While this has been proposed in Canada and implemented elsewhere,[77] it has yet to be discussed or integrated at the federal level.

A Mental Health Impact Assessment can support mental health mainstreaming in the same way that the federal government's Gender-Based Analysis Plus (GBA+) framework has recently bolstered gender mainstreaming in government policy. GBA+ starts from the premise that policies have different impacts on people depending on their social location, and, as a result, people's experiences must be documented in order to identify and address how policies will have different impacts on the basis of not just gender but also race, class, sexuality and ability, among other axes of identity.[78]

A Mental Health Impact Assessment would encourage consideration of the mental health implications of current and proposed federal decisions, ensuring that mental health is considered as part of deliberations on policies, projects, programs, and laws made and enacted by governments and agencies at all levels. This deliberation must necessarily include collaboration and consultation—with community members, Indigenous communities, researchers, and mental health and public health providers—to reflect and incorporate experiences towards decision-making and priority-setting that protects and promotes community mental health.



There are several benefits to identifying the adverse or potentially adverse mental health impacts of government decisions. It can highlight for decision-makers the ways in which mental health is unequivocally mediated by social determinants of health (e.g., education, safety, social inclusion, housing and employment).[79] A Mental Health Impact Assessment can, like GBA+ is doing, support data

collection on the needs, priorities, capacities, experiences, interests and views of differently situated children and youth, women, men and gender-diverse people, vis-à-vis mental health.[80] It would also compel program design, research, and policy to acknowledge and attend to the factors that impact individual and population mental health and ensure that policies and programs support the mental health of all people in Canada.

RECOMMENDATION

2 In the short-term, strengthen the evidence base for mental-health-promotion-based policy-making by supporting research that draws on economic analysis and program evaluation; in the medium- to long-term, boost research funding to support the collection and analysis of epidemiological and economic data to identify key priorities for mental health promotion programming.

Advancing MHP is a matter of concurrently assessing the financial cost of mental health problems and mental illness and the impact of early intervention on population mental health. In this regard, performance measurement and assessment are valuable to MHP because they provide evidence to cultivate a culture of accountability, aid in the identification and prioritization of economically efficient programs, enable program monitoring, and help health-care decision-makers and funders recognize a program's value.[81] Currently, program evaluation, resource use pattern analysis, cost-benefit analysis, and economic modelling are all frequently employed to measure the economic and/or social impact of mental health promotion programming.

The growing evidence base for the effectiveness of mental health promotion programs profiles the impact of promising efforts across the life course through a variety of sources of evidence, including RCTs and cost-benefit analyses. Experts in Canada, the US, the UK, Australia, and the Netherlands, for example, have produced considerable and compelling evidence that makes the economic case for mental health promotion, demonstrating return on investment in terms of cost-effectiveness and cost-avoidance.[82] Overall, in Canada, there is limited awareness of the cost-effectiveness of MHP despite the implementation of numerous programs across the country. An early Canadian study that compared community-based parenting interventions with clinic-based interventions found that both were effective in reducing the risk of conduct disorders in children but that the community approach was six times more cost-effective because it reached more parents.[83]

The impact of MHP is better recognized in comparable jurisdictions. A 2003 meta-analysis of economic studies of home visiting programs targeting high-risk mothers in the US found net benefits of 2:1 or $6000 per mother.[84] In the Netherlands, a controlled trial compared a stepped care approach to the prevention of depression in older people with routine primary care for the same population and found the former to be both effective (halving the incidence of depression and anxiety) as well as cost-effective at a savings of €4367 per depression/anxiety-free year gained (with one out of every eight participants gaining a year).[85] A recent US study of social and emotional learning (SEL) interventions delivered at the K-12 level found a benefit-cost ratio of 7.1, on average.[86]

Recent analysis of KiVa, an anti-bullying program with its origins in Finland, found that it returned £1.58 for every £1 invested.[87] A recent cost-benefit analysis, which draws on the data of 663 Swedish students to examine the impact of a social and emotional learning intervention on students' drug use, found that the program cost $540 USD/student to implement but netted $7510 in benefits, measured against current expenditures for problematic substance use among youth by US health care, criminal justice and judicial systems.[88]

However, precise examination of the economic return on investment remains difficult due to a combination of methodological challenges, limited resources for measurement in certain settings, and a lack of available longitudinal data. Overall, there is a lack of reliable population data on participation rates and program impact, which means that it is difficult to determine or declare with confidence the economic and social return on investment of MHP programs. In other words, although evaluations of individual programs abound and show these programs to be effective, critical evaluations that consider the long-term impact of MHP programs are scant. Complicating these limited measurements is a lack of standardized measures or methods for determining fidelity and effectiveness.[89] For example, some studies have teachers use logs, some use student questionnaires, while others use observations.[90] It is also difficult for school and community settings to undertake robust or independent evaluations and/or RCTs, due to funding constraints that limit the scope of evaluation.[91] Researchers and public health professionals have indicated that more robust evaluation, including longitudinal evaluation, is integral to continued development.[92]

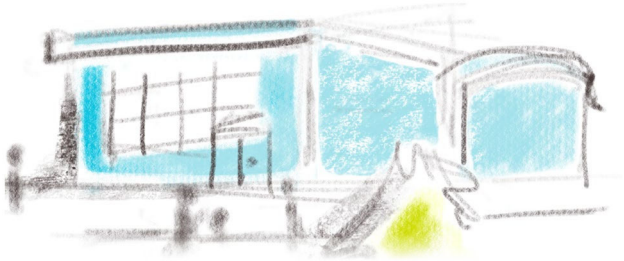
In Canada, a lack of comprehensive population data and methodological standardization impede effective economic return on investment/social return on investment (EROI/SROI) analyses.[v] Consequently, other measures have been developed to determine EROI. In the K-12 context, these include the School Mental Health Quality Assessment Questionnaire (SMHQAQ), which assesses the progress of school mental health efforts and works to increase quality practices in school mental health.[93] Canadian experts also look toward the UN's System of National Accounts, an internationally agreed-upon set of recommendations for compiling measures of economic activity, but they recognize that the adoption of such measures depends on improving the quality of Canadian data on mental health care use in outpatient and community mental health services.[94]

Economic return on investment of MHP is measured via synthetic data analyses, economic modelling, intervention modelling and decision tree modeling. Assessments that demonstrate positive results for an intervention are typically based on short-term or project-based interventions, which means that modelling studies also have short time horizons.[95] As such, large-scale, long-term assessments of multiple projects tend to be untenable in the confines of granting and funding structures. Economic

v Some calculations determine a treatment's economic value based on calculated increases in quality-adjusted life years (QALY) gained or disability-adjusted life years (DALY). It is beyond the scope of this paper to detail how these measures work in the MHP context. They are widely used, albeit less prominently in Canada, but have also been critiqued for assigning high value—and consequently funding—to treatments that provide the greatest extension of life, in turn excluding other valuable treatments, and because they disadvantage people with disabilities who are unlikely to achieve the "maximum" quality of life. Others have critiqued these measures based on their inability to determine whether the reported cost savings are effective uses of health care resources compared with alternative uses, which are not simultaneously considered in these measurements. For more information on the use of QALY and DALY in Canada, see: Jacobs, P., Knoops, F., & Lesage, A., "A Review of Measures of Aggregate Mental Health Costs in Canada," *Canadian Journal of Community Mental Health, vol. 6, no. 4 (2018): 1-17.*

models presuppose that program costs and program management are borne by the implementing entity (e.g., school, workplace) or by a funder or granting agency. In this context, economic modelling is leveraged to consider the impact that MHP programs can have on measures such as access to mental health services, participation in formal employment, continuation in formal education, and reductions in rates of violence and crime, by comparing these to longitudinal country data on education, employment, disease prevalence, and incarceration rates.[96] But, it is challenging to accurately or precisely estimate how a short-term intervention might influence a participant's (or population's) behaviour over the longer term and how other factors or interventions might interact with or counteract the intervention being examined.[97] Further methodological challenges include very limited opportunity for the introduction of control groups into an intervention for investigatory purposes.[98] For example, most jurisdictions that engage in MHP have not reported expenditures and may not have the measures to report.[99] Although there are challenges to precisely determining the economic value of MHP interventions, economic assessments demonstrate the impact of MHP programs on individual and community mental health as well as the capacity of said programs to offset expenditures to the mental health, justice, and primary care systems.

The social impact and value of MHP programs is often determined through evaluations, which are conducted to measure whether a program has achieved the outcomes intended for the program's participants or beneficiaries. Evaluations advance knowledge regarding the implementation and effectiveness of MHP interventions in relevant settings. An RCT of a Dutch mental health promotion program based on behavioural therapy and mindfulness found that, compared with participants in the wait-listed control group, participants in the intervention group had greater emotional and psychological well-being after the intervention; they also reported greater psychological flexibility at follow-up, which mediated the effects of positive mental health.[100] Zippy's Friends, a program that originated in Denmark and now teaches social and coping skills to more than 1 million children in more than 25 developed and developing countries, has been extensively evaluated. Key findings from RCTs, including cluster RCTs conducted in Canada,[101] are that the program has had significant, positive effects on children's coping strategies and adaptive coping skills, social skills, emotional literacy skills, and has reduced mental health difficulties or problems that arise from stressful situations.[102] Evaluations of comparable programs, including Strong Start, Mindfulness-Based Stress Reduction MSBR and RALLY, have identified improved coping and stress management skills and improved psychological functioning among student participants.[103]



Broader social and educational impacts have also been identified, particularly in Norway, where MBSR has improved the social climate in classrooms, reduced incidents of bullying, and improved academic skills among student participants.[104] As MHP efforts are now underway in developing countries, these are starting to be evaluated. In Lebanon, for example, a process evaluation of the Qaderoon program—a relationship, communication, and problem-solving skill-building program for children living in a Palestinian refugee camp in Beirut—found that

although attendance was low (38–54%), over 90% of the students who participated indicated a high rate of satisfaction with the activities.[105] Such outcomes indicate the significant impact that MHP initiatives have had in a variety of locations and contexts.

There are, however, important socio-political concerns that emerge in the context of defining the evidence base for the economic return and/or social value of MHP programs. Far from producing "unequivocal evidence," RCTs and other evidence-based methods (e.g., systematic literature review, statistical meta-analysis) are methodologically and ideologically fraught,[106] as they hold inflexible ideas about what constitutes evidence, what evidence is collected, and what results are shared. Although Canada's population is increasingly diverse, MHP programs targeted to or inclusive of minorities represent a fraction of programs, are "limited in number and typology and unevenly distributed across the country" with concentration in major metropolitan areas.[107] Evaluations risk privileging the experiences of particular consumers/participants. Few methods distinguish findings along axes of identity such as gender or race; in turn, it is difficult to determine cross-cultural validity, or the degree to which reported positive effects hold for participants from vulnerable populations.[108] The reliance on quantitative data elides the fact that cultures provide their own forms of evidence, including "interpretive frameworks, notions of authority, and standards of truth."[109] Evidence is neither produced nor applied equally, in that "biomedicine and psychiatry are also traditions that convey not only technical scientific knowledge but also whole systems of cultural values and practices" that preclude Indigenous and/or non-Western worldviews.[110] In Canada in particular, problems with evaluation are amplified because many Indigenous communities remain distrustful of research due to the physical, cultural and spiritual harm that Western research programs and methodologies have done throughout modern history.[111] Short-term investments in mental health promotion must include the enhancement of evaluation research and economic analysis of MHP by incorporating non-majority experiences, forms of evidence, and worldviews.

At the same time, long-term investments in economic analysis are vital, specifically to support the development of analyses that can consider population- and community-level impacts. While evaluation research and economic analyses have been conducted in peer jurisdictions, as outlined above, Canadian analyses are limited despite the well-developed MHP landscape in Canada. At present, the majority of assessments of MHP focus on individual-level impacts because these are less complex to evaluate and can directly demonstrate a rate of return (e.g., the impact of stress management on worker absenteeism and productivity).[112] In the medium- to long-term, investments in research to collect and analyze epidemiological and economic data is important so that population- and community-level benefits can be measured and so that key priorities for program replication and scaling can be identified. In this case, it is vital to translate this evidence into initiatives, clinical practice and service delivery.[113]

In addition, data from MHP interventions, particularly data from underserved populations, can form a basis for strengthening the understanding of the impact of these efforts, and timely access to this data can support decision-making to improve the programming landscape, the allocation of resources and the delivery of services. With regard to programming, researchers have concluded that, due to the multitude of existing mental health promotion programs and initiatives that are currently available,

it is crucial to establish data collection guidelines and key indicators to identify high-fidelity programs with high rates of participant engagement and retention.[114] These efforts can be advanced through collaboration between governments, academic research, the education sector, and the health care system.

RECOMMENDATION

3 Guarantee ongoing support for mental health by increasing, from 7.2% to 9%, the funding allocation for mental health in Canada; ring-fence federal funds for the enhancement and streamlining of mental health promotion programming and the development of cross-sectoral/ cross-jurisdictional partnerships for mental health promotion.

Substantial investment is needed to support the development of individual and community-based protective factors for good mental health, thereby enhancing the well-being of people whether or not they live with a mental illness. Yet, most developed and developing countries, including Canada, underfund mental health.[115] In Canada, with mental health expenditure at just 7.2% of the health care budget, Canada spends among the lowest proportion of funds on mental health in the G7.[116] It also spends less than its peers: in England, by one recent estimate, 12%–18% of all NHS expenditure on long-term conditions is linked to poor mental health and well-being, equating to around £1 for every £8 spent on long-term conditions; however, the OECD's recent analysis of spending on mental health worldwide concluded that this expenditure may be conservative against England's overall disease burden.[117] The historical underfunding of mental health in Canada has been most pronounced in community-based mental health services where counselling, psychology, social workers, and specialized peer support are not covered by its "universal" health care system.[118]

Just as chronic underfunding of primary and community care for mental health remains a persistent barrier to mental health support, there is also persistent underfunding of approaches based on prevention and early intervention. Yet, as outlined earlier, the upstream measures and early intervention approaches that underpin MHP, such as cultivating supportive environments fostering socio-economic inclusion,[119] can generate significant mental health impact for individuals and communities and reduce mental health expenditure.[120] Despite a growing body of literature and political attention to early intervention and preventative efforts, most of the organizations and institutions that can subsequently drive MHP (and where MHP has the greatest potential to thrive) (e.g., education) are underresourced, which hinders capacity to achieve the objectives of the MHP mission writ large.

An overall spending increase of at least 2% is urgently needed to improve and protect the mental health of people in Canada. Overall, such an increase is essential to meet the unmet need for timely, accessible, and appropriate supports. A share of this 2% increase must be ring-fenced in service of the enhancement, streamlining, and rigorous evaluation of mental health promotion initiatives across settings (i.e., schools, communities/homes, workplaces). Specific funding can support the introduction of MHP

into communities and settings that are currently not being reached; on the other hand, funding is vital to facilitate the long-term sustainability of programs that are effective or demonstrate the potential to be. (A list of MHP programs, developed and/or implemented in CMHAs, research institutes, and public health units across Canada, as well as high-impact international programs, is presented in Appendix 1.)

Enhanced and ongoing financial support for MHP would ensure that interventions are sufficiently resourced, well-equipped for assessment and improvement, and robust enough to validate policy and advocacy efforts. It could especially bolster those initiatives designed to include vulnerable populations in school and community settings by leveraging appropriate models, implementation strategies and outcomes measures. It is challenging to implement MHP in community settings because they are complex, diverse and cross other settings such as schools. Community organizations and agencies, for example, report "limited and inconsistent funding [which] required [them] to cut back on projects and limit their programming" in part because they were unable to support multilingual staffing, translated materials and trained interpreters.[121] Ethnocultural services also report that their constituents face barriers to access due to limited availability in combination with language and cost barriers, distrust of mainstream services, and stigma around help-seeking.

In the K-12 and community context, the "normative scenario" is one in which MHP is done with "limited funding and without formal research support."[122] Schools often lack the necessary resources to adequately train, supervise and support staff; to implement strategies that would assess and improve service quality; and to document outcomes, which can support sustainability and influence policy.[123] These initiatives are also confined to the boundaries of the classroom or school environment and thus are unable to reach those who may particularly benefit, such as early school leavers, students with high rates of absenteeism, home-schooled children, and youth in transition.[124] More often than not, schools become able to deliver an MHP program through support from special initiatives or research grants; however, teachers report that they find it challenging to implement all of the activities in the allotted time frame and experience difficulty securing parent buy-in, especially for evaluations, given the stigma around mental illness and concerns about the age-appropriateness of discussions of mental health. In Canada, a primary obstacle to making significant inroads in school mental health promotion is the lack of federal-level support, meaning that efforts remain at best provincial, resulting in a patchwork of approaches with considerable variability in length, reach, structure, and approach and with limited capacity for monitoring and evaluation.[125] When program resources expire, so, too, do the quality and/or life of these programs. Considering that investment in MHP contributes to broader health outcomes including the reduction of risky behaviours (e.g., smoking, substance use, unhealthy relationships) and the retention of students in education,[126] it is vital to expand capacity for implementation. Teachers have an immediate understanding of the student body and their help-seeking strategies and behaviours, but teachers themselves must be empowered to foster their competency in MHP through professional development opportunities. However, because most teachers are not trained in mental health or interactive health education, execution remains a

challenge; in turn, it is important that public health agencies supplement a school's efforts, particularly where evaluation is concerned.[127] But, any investment must be made in the context of an intentional, coordinated and streamlined effort that concurrently enhances institutional investment (i.e., school and school board) and enhances capacity to support MHP efforts (e.g., support for teachers).[128]

Additional investment in MHP should also be directed in support of the development of cross-sectoral and cross-jurisdictional partnerships between employers, educational institutions and community organizations. Where vulnerable or underserved populations are concerned—youth, seniors, and newcomers, for instance—multiple sectors may become responsible for addressing mental health problems (e.g., education, health care, social services). Cross-sectoral collaboration can bridge service, context and expertise to tailor approaches, interventions, and assessments. At present, linkages between schools and community mental health resources or between workplaces and community mental health tend to be un- or underdeveloped; this lack of connection throws up barriers to developing programs in the contexts in which people live.[129] It also generates barriers to program evaluation and cost-benefit analysis, for if there is limited or no access to data from related touch points, it is difficult to measure the impact of MHP efforts on things like service use or costs to the health care system (or other systems). Partnerships between schools or workplaces and mental health services can support the identification of cross-cutting themes and priorities for mental health and develop MHP-oriented policy and programming solutions.[130] Partnerships can also support program delivery in settings that may be under-resourced or underserved due to geography, funding constraints or other reasons. However, it is imperative for these partnerships to be developed with long-term sustainability in mind to support streamlining and continuation of effort.[vi]

RECOMMENDATION

4 Replicate, scale, and make sustainable population-based programs that have been evaluated as accessible, culturally safe and intersectional, and that account for the social determinants of mental health.

Over the past decade, compelling evidence has emerged from industrialized and developing countries to indicate that mental health promotion reduces risk factors for mental and behavioural problems, enhances the protective factors for well-being and has a positive impact on interrelated health outcomes (e.g., academic, employment, and physical health outcomes).[131] Despite this progress, national-level investments in MHP remain limited and it remains challenging to translate program-level effectiveness into large-scale transformation. This may be the case because, as some critics point out, understandings of MHP and MHP efforts have been unfocused, which has unfortunately led in many cases to fragmentation and duplication rather than coordination of effort. If MHP is to be effective in the long-term, greater federal-level investment is necessary to support a focused centralization of effort wherein a complement of inclusive, evidence-informed programs is translated across Canada. In addition to investing in the

vi To take one example, the international, 300+ member network INTERCAMHS created an international opportunity for networking around student mental health, yet due to lack of ongoing funding, ceased active operations in 2013; in 2014, another consortium, the School Mental Health International Leadership Exchange (SMHILE), had to be created anew to support cross-border knowledge and information sharing.

replication and scaling of effective, evidence-informed MHP programs in order to streamline and reduce duplication of effort, a concerted effort must be made to build inclusive and intersectional MHP that supports all people and communities in Canada. Currently, Canada's mental health system struggles to effectively support Indigenous peoples in Canada, newcomers and refugees, religious minorities and people of colour.

Attentiveness to identity and context calls for and aligns with an intersectional approach to program development, implementation and evaluation, the importance of which is increasingly emphasized by health researchers[132] and public sector decision-makers.[133] Intersectionality is a framework that recognizes that the experiences of individuals who belong to more than one minority class (e.g., racialized women; women with disabilities) are compounded on this basis, but that traditional structures, such as the law, tend to marginalize one or another axis of identity and are unable to simultaneously attend to multiple categories of experience.[134] Presently, intersectional approaches work to address the multiple and intersecting categories of identity in the development of programs, curriculum, and policy.

Mental health is a multi-dimensional phenomenon "determined and constituted [by] the social context in which people and communities exist."[135] People's experiences and identities thus manifest in their health status, and so the most transformative approaches to mental health promotion are and will be those that adopt frameworks or approaches that account for "people's identities, the places they live, and those with whom they engage."[136] Such efforts are integral to supporting reconciliation with Indigenous peoples and increasing social equality for traditionally underrepresented groups. Health interventions are frequently developed without regard to the "social, political and cultural context of health in Indigenous populations" and in other minority populations.[137] Efforts should be made to replicate, scale and make sustainable MHP initiatives that, through an intersectional approach, address mental health as that which is experienced at the individual level yet is immediately and intimately connected to the social and systemic context. This means bolstering evidence-informed programs that demonstrate effectiveness or have the potential to be effective for diverse communities if replicated and scaled for the whole population, including through reaching Indigenous persons in Canada, newcomers (including immigrants and refugees), girls and women (including pregnant women and new mothers), older adults, members of the LGBT2SQ+ community, unemployed persons, and people with disabilities.

In order to reach non-majority, multi-barriered and/or vulnerable communities, MHP efforts must be accessible, cost-effective, culturally safe, linguistically appropriate, attentive to axes of identity, and inclusive of the socio-economic context in which people are situated.[138] The transformative potential of designing, implementing and evaluating MHP programs through an intersectional lens cannot be underestimated. In a climate of persistent health

inequity and steadily increasing diversity in Canada, the development and evaluation of services and programs that acknowledge and address multiple axes of identity must be a priority.[139] However, intersectionality has yet to make "significant strides in transforming health research and policy."[140] An intersectional MHP framework can support the development, integration and/or implementation of initiatives that align with the principles of equity, inclusivity and reconciliation. Bolstering MHP efforts that take an intersectional approach and building intersectionality into others will ensure that MHP meets its transformational goals: efforts that take as their starting point identity, culture and worldview can be endorsed as those that address social inequality and structural disparity as a contributing factor in poor mental health. One longstanding critique of early intervention approaches, including MHP, is that they tend to focus on individual-level interventions at the expense of environmental or social change, even though mental health problems more often arise as a result of environmental or social inequality (e.g., poverty; discrimination; unemployment).[141] MHP efforts that are oriented by a majority-culture approach will be limited in their ability to effect change because they will be ill-equipped to account for the multiple and intersecting cultural, linguistic and systemic barriers that vulnerable people in Canada encounter.[142] In turn, it is crucial to focus investment on MHP programs that are or can be intersectional.

For Indigenous people in Canada, traditional and contemporary health includes mental health.[143] However, in Canada, the disintegration of Indigenous communities has negatively impacted not only the cultural and social systems of those communities but also the spiritual and mental health of Indigenous peoples.[vii] The historical origins and ongoing contemporary effects of European colonialism for Indigenous peoples in Canada are well documented. Policies of forced assimilation upon early contact resulted in initial and ongoing cultural oppression.

Missionary activity attempted to "save" and "civilize" Indigenous peoples through conversion, which included the suppression of language, belief systems, cultural practices that ensured sustenance, and familial separation. Economic and trade policies were typically arranged without the input of Indigenous peoples or regard for Indigenous values or relationship to the land.[144] The lives of Indigenous peoples continue to be heavily monitored and managed by government policies such as the *Indian Act*.[145] As a consequence, when it comes to mental and physical health, Indigenous peoples in Canada have increased risk factors, reduced protective factors, and more disappointing outcomes.[146] The "mental health crisis in many [Indigenous] communities, is in part exacerbated by the under-use of mental health services by Indigenous peoples."[147] In addition to oft-cited problems of access and wait times, services are often not oriented around an Indigenous conception of health or helping but rather in the epistemology of Western health and biomedicine. MHP offers potential to meet the unmet needs in Indigenous communities but it must be linked with reconciliation and decolonization efforts: MHP's grounding in the social determinants of health (as informed by its origins in health promotion)

vii The diminishment of social, psychological, and physical health includes, but is not limited to, higher incidence of chronic disease, higher mortality rates, including deaths by suicide, higher rates of incarceration, family and sexual violence, and children in the custody of agencies. For further detail on the mental health consequences of cultural suppression and forced assimilation on Indigenous peoples in Canada, see: Kirmayer, Laurence, Cori Simpson, and Margaret Cargo, "Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples," *Australasian Psychiatry vol. 11, no. sup1 (2003): s15-23.*

and focus on creating the conditions for people to control and improve their own health encourages this.[148] MHP efforts that include Indigenous peoples must be cognizant of local tradition, be available in commonly spoken and/or regionally appropriate Indigenous languages, be executed in accordance with the Indigenous Wellness Framework, be conducted wherever possible by Indigenous *and* non-Indigenous persons, recognize Indigenous customs of behaviour such as respect and non-interference, and meaningfully engage and incorporate input from Elders and youth.[149] Yet, despite a number of guidelines for how to integrate Indigenous persons, teachings, and values into mental health promotion (and health promotion more generally), explorations of Indigenous approaches to resilience and assertions that Indigenous culture can independently build mental health,[150] examples of decolonized MHP programs remain limited. In an early review of MHP for Indigenous youth in Canada, Lewis Williams and Zubia Mumtaz write:

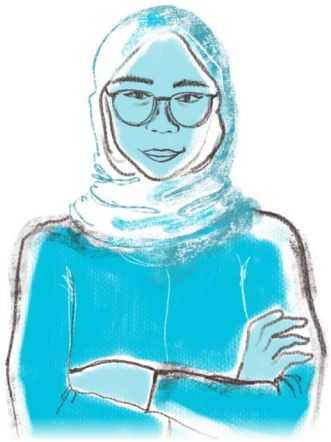
> *given the current socio-economic, cultural and power inequities that accompany disparities in mental health and well-being between Aboriginal and non-Aboriginal groups in Canada… conceptualizations of MHP must go further than respecting constructs such as equity, culture and social justice. Rather, definitions and practice must actively build these concepts through MHP activities ultimately aimed at addressing structural inequities, the root cause of disparities in mental health status between groups.*[151]

In addition to acknowledging the specific protective and risk factors generated through Indigenous peoples' experiences of colonialism and systemic inequity, MHP efforts must also allow for diversity and consider the different perspectives on health and well-being that exist among Indigenous peoples.

Since Williams and Mumtaz's review, several culturally safe interventions that follow Indigenous values and teachings have been developed for Indigenous populations in Canada. Reclaiming our Ancestral Footsteps, an MHP program for Mi'kmaq and Maliseet youth in Elsipogtog First Nation, promotes mental health strategies among Wabanaki youth though a strong foundation in Wabanaki culture and values. Caring for the Circle Within is a land-based healing program in Kwanlin Dün First Nation that interweaves Western clinical and First Nations healing approaches to support adults dealing with intergenerational trauma, and has reported high rates of satisfaction, including evidence of increased resiliency, across three evaluations.[152] Perhaps one of the most productive programs is the PHAC-funded Listening to One Another to Grow Strong, which focuses on strengthening cultural identity, family communication and support, problem-solving skills, and emotional regulation for youth aged 10–14 and their parents. Adapted from a non-Indigenous program called Strengthening Families, Listening to One Another to Grow Strong showed high rates of gains in anger management and enhanced family communication and parental involvement in the lives of youth.[153] In five years, the program was culturally adapted across 14 communities and five First Nations, which are in the process of ongoing evaluation.

Social and economic marginalization also impact the mental health of non-Indigenous people of colour in Canada and of members of other vulnerable communities. For instance, poverty and systemic racism continue to influence the experiences of people of colour and have been shown to have an unfavourable impact on mental health, particularly among first-generation Canadian children and youth of colour.[154] Systemic racism may impede the availability of appropriate mental health services—wait times are high and culturally safe services are

chronically underfunded[155]—an experience that is compounded when people of colour experience additional health challenges or complications.[156]



Canada is home to a growing number of newcomers, immigrants and refugees. The migration and acculturation processes can be difficult and traumatic for newcomers, and, in turn, can be deleterious to mental health. For refugees in particular, migration may reduce access to sustenance and shelter, necessitate movement through difficult spaces, separate migrants from family and loved ones, and disrupt personal development. Any or all of these experiences can have a considerable impact on an individual's mental health.[157] The acculturation process presents an additional set of challenges that can also negatively impact mental health. For example, newcomers who were advancing in their careers at the time of migration may experience upon their arrival a decline in their socioeconomic status caused by unemployment, deskilling, reduced income, and/or employment discrimination.[158] These experiences may contribute to deterioration in mental health, provoking feelings of isolation, exclusion, helplessness, and powerlessness.[159] Further, experiences of racism, which are pervasive, may lead people of colour to question their acceptance in Canadian social and economic networks, or as members of Canadian society, and have a significant impact on mental health.[160] Despite this, many mental health professionals struggle with how to address the consequences of racism and systemic oppression in clients' lives and while many anti-oppression trainings are available to mental health professionals, more work is needed to strengthen the role of anti-oppression in the adaptation and implementation of MHP programs.

MHP efforts built on a recognition of identity and the principles of cultural safety and accessibility can advance the comprehensive restoration of cultural values and facilitate a secure sense of cultural and social identity. MHP means reconsidering approaches and reviewing programs such that they incorporate non-Western views of health/mental health that are, on their own, legitimate frameworks that do not need to be validated by dominant frameworks. Going forward, MHP must continuously align with the values and needs of vulnerable and typically underrepresented communities. To achieve this, it is paramount to involve and empower communities that would benefit from MHP.

Indigenous persons and persons of colour, especially young Indigenous persons (the fastest-growing population in Canada),[161] must be integrated into high-level decision making on MHP research and practice specifically because Indigenous peoples have been excluded from these processes.[162] The participation of traditionally underrepresented communities supports community empowerment, which, as Laurence Kirmayer et al. note, is "a cardinal principle of health promotion, involves a shift from a top-down approach to the design and implementation of categorical health programs to community processes aimed at engaging community members in decisions

that affect them in the context of their everyday lives."[163] This may require recognizing and bolstering "undocumented and under-resourced" initiatives that promote mental health but that are not formally recognized as MHP.[164] Yet, if MHP efforts start by facilitating and nurturing a secure sense of culture and worldview for Indigenous peoples, for example, then people of colour communities will have access to culturally appropriate means of self-expression, which is recognized as central to mental health and self-determination.[165] More broadly, the meaningful inclusion of people of colour communities can ensure that MHP interventions capture and meet the needs of end users "more effectively in the context of local capacities and resources."[166]

Advancing intersectional MHP does not require investments in distinct or new programs; rather, it requires building in intersectionality—via program design, delivery and evaluation— to programs that work. Individualized strategies to manage emotions, encourage help-seeking, and build resiliency in vulnerable populations cannot eliminate the racism, discrimination and systemic inequity that continue to impact mental health. In turn, MHP efforts must be complemented by meaningful policy and social changes that ensure freedom from violence and discrimination and promote social and economic inclusion.

RECOMMENDATION

5 Enhance the impact of mental health promotion in Canada through investment in social marketing campaigns that enhance mental health awareness and reduce stigma.

The need to challenge stigma is a recurring theme in research, advocacy and policy on mental illness and other experiences of disability. Research on mental illness and the accounts of people who live with mental illness have demonstrated that mental illness, as an experience and an entity, generates stigmatizing reactions from the public and institutions.[167] The symptoms, disability, and distress that accompany the experience of mental illness or serious mental health problems are frequently complicated by stigma, by social discrimination and by the injustice experienced by people who live with mental illness. Although advocacy and consciousness-raising efforts are beginning to advance public conversation around mental illness, stigma persists among professionals, the public, and in the media.[168]

Stigma is premised upon an "undesired differentness" that is defined by stereotype, perpetuated by prejudice, and mobilized by discrimination. Stigma creates a situation wherein the stigmatized individual or group is "disqualified from full social acceptance" and participation.[169] A variety of stereotypes about, prejudices against, and discriminatory behaviours towards people who live with a mental illness that are attributable to the stigma of mental illness have been identified in recent research. These are often joined into four categories or types of stigma: public stigma, self-stigma, label avoidance, and structural stigma.[viii] The immediate and long-term consequences of stigma are considerable. For example, disclosure of a mental illness to colleagues and acquaintances has been linked to less supportive and stronger

viii Although this section decidedly emphasizes the impact of stigma for individuals, the intention is not to elide a discussion of the broader context or socio-political conditions that create and perpetuate stigma. For a fulsome discussion please see Corrigan, Patrick, *On the Stigma of Mental Illness. Washington, DC: American Psychological Association, 2005.*

stigmatizing reactions.[170] Stigma has been negatively related to employment and income among people with a mental illness, and the perception of stigma has been negatively related to self-esteem.[171]

The public endorsement of stereotypes about and prejudice against people who live with a mental illness generates counter-factual discourses of mental illness and mental health. Stigma impedes access to mental health care in primary and community settings and compromises the life chances of people who live with a mental illness. People who are struggling with their mental health and/or who experience a mental illness might not seek or might discontinue services to avoid being associated with mental illness or poor mental health.[172] The stigma of problematic substance use may be even greater. To take but a few examples, stigma impacts how people are treated in the health care system, enables discrimination in employment via substance use policies, and underpins key messaging in drug-free campaigns and advertising.[173]

Because stigma has meant that "the opportunity to prevent and alleviate mental health problems has so far largely been missed"[174] stigma reduction is an essential objective of MHP. Specifically, if MHP is to achieve the goal of prevention and early intervention, alongside the cultivation of healthy environments, ending stigma must be a central component of MHP efforts. We view it as optimistic that stigma reduction has become part of mental-health-related program development and policy-making.

The counter to stigma is empowerment. Shifting stigma's hurtful and harmful effects cannot be achieved by eliminating discrimination; stigma needs to be "replaced by affirming attitudes and behaviours," including emphasis on recovery and self-determination and the provision of accommodation and inclusion.[175] Because stigma is a social construct, it can be addressed with social-level interventions. Among these are public awareness campaigns—also called social marketing campaigns—which combine marketing concepts with ideas and practices from health promotion in order to influence behavioural changes that benefit individuals and communities. Although stigma reduction is a key indicator in MHP initiatives and is frequently cited as a positive effect and/or outcome in evaluations thereof,[176] there is nonetheless a case to be made for distinct, whole-of-society campaigns that work to address and reduce stigma, whether independent from or as a complement to active MHP efforts.

Proponents of social marketing campaigns recognize their relevance to building awareness about mental health and to local and systems change.[177] The outgrowth of public service announcements, social marketing efforts typically leverage social media by providing opportunities for people and organizations to publicly share up-to-date information, encourage people to adopt strategies and set goals, and highlight and share evidence-informed practices. Generally organized around a series of key messages, campaigns include engagement activities for awareness building (e.g., quizzes; toolkits) and banners/icons and shareables for social media.

In the Canadian context, several national- and provincial-level interventions have been developed to enhance mental health awareness and reduce stigma. However, none receives federal funding. CMHA's annual Mental Health Week activities, which have run each May for 68 consecutive years, include the annual #GetLoud campaign, a week-long public education campaign created to reduce stigma associated with mental illness. In 2018, the grassroots campaign focused on educating Canadians on the difference between mental health and mental illness to encourage understanding that mental health is something that all people should protect, celebrate and promote. The Mental Health Commission of Canada's (MHCC) *Opening Minds* program targeted stigma reduction in youth, health care providers, the media and workplaces. A recent evaluation demonstrated the program's effectiveness regarding stigma reduction among pharmacy studies,[178] while another RCT of the program found that it significantly improved medical students' attitudes towards mental illness upon completion of the program when compared with baseline.[179] Bell *Let's Talk*, Canada's most well-known campaign in recent years, donates $0.05 CAD to mental health research and programs for every usage of the campaign's hashtag and campaign tweet and for every call or SMS text message sent on its network. A recent, internally conducted evaluation of the campaign surveyed over 1000 adults, who reported that they felt the campaign was successful at decreasing stigma (57%), increasing personal awareness (81%) and positively changing attitudes toward mental health (70%).[180] At a population level, another study of data on youth aged 10–24 found that, following the 2012 Bell *Let's Talk* campaign, mental health service utilization increased overall, both in terms of increased visits by current consumers and new visits.[181] Other stigma reduction campaigns proliferate across Canada. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) hosts Mental Illness Awareness Week, a national public education campaign in October that features, for instance, stories of people with lived experience of mental illness. In addition to these whole-of-society approaches, a range of regional, practitioner-specific campaigns also operate in Canada, including those for physicians and youth, such as Ottawa Public Health's *Have THAT Talk* campaign.

Internationally, several comparable anti-stigma initiatives have been implemented. Among the most notable is the Time to Change Campaign, a UK-based social movement designed to change thought patterns about mental health problems and reduce stigma and discrimination by 5%. With the support of national funding, the program reaches all identified MHP settings: it fosters initiatives in the workplace, supports workshops and assemblies in schools, and creates network-building and community champions. The program has demonstrated moderate but positive improvements associated with the campaign, in relation to attitudes but especially in relation to intended behaviour. Over

its decade-plus existence, population surveys have demonstrated that overall attitudes have improved by 9.6% (4.1 million people), people's willingness to live and work with people with mental health problems improved by 11%, and average levels of reported discrimination faced by people who live with mental health problems decreased from 41.6% to 28.4%.[182] Overall, discrimination in social and familial circles and in employment met or exceeded this target; unfortunately, discrimination experienced by people with mental illness in the health care context did not change.[183] In addition, Australia's Act-Belong-Commit has also shown a high degree of impact vis-à-vis stigma reduction. Recent interview-based impact evaluations of the Act-Belong-Commit campaign in Western Australia found both the control group (58%) and the group that had sought help for mental illness (66%) identified stigma reduction as an outcome of the campaign.[184] An evaluation of The Compass Strategy, an Australia-wide community-based mental health literacy program for young people, determined that the program made mental health information more accessible and improved attitudes towards help-seeking and its benefits.[185] In addition to these, other programs include *It's up to us* and #StigmaFreeSD (San Diego, CA), *One of Us* (Denmark), and *See Change* (Ireland).

Public awareness or social marketing campaigns have considerable potential to be an innovative and productive approach to reducing stigma and increasing mental health awareness and literacy. They are worth investing in because they can effectively bridge the information deficit about mental health in Canada in a way that can leverage technology and that does not have technology or transportation challenges. Whole-of-society campaigns can educate people about mental health, encourage individuals, social and professional communities, and workplaces to introduce into their settings a mental health lens and in turn make and act on mental health-related decisions. Investment in social marketing/public awareness campaigns reduces stigma because these campaigns can create a shared language and understanding of mental health and offer an opportunity for people to learn about and share strategies, successes and challenges.

A recent *The Lancet Psychiatry* review of approaches to reducing the prevalence of mental illness and mental health problems suggests that "awareness" includes public awareness campaigns about early signs and risk and protective factors as well as information about the health consequences of mental illness to encourage timely help-seeking. Its authors recommend that such awareness be grounded in messages about the social benefits and economic savings of being proactive.[186] Two recent scoping reviews suggest that, for MHP to be as effective as possible over the long-term, it requires direct and repeated contact with target individuals and communities. Such sentiments have been echoed in Canada at the provincial level: as part of its recently launched *Wellness Strategy 2014–2021*, the government of New Brunswick recognized social marketing as one part of a comprehensive, long-term approach to social change around mental health and well-being.[187]

Efforts are currently being made to recognize and invest in initiatives that have the potential to serve as vehicles for transformation. A number of campaigns have been launched across Canada and in peer jurisdictions, and early outcomes studies indicate the promise of such campaigns for stigma reduction and behaviour change. In the US, the Caring for Every Child's Mental Health Campaign, which is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), aims to increase awareness of children's mental health issues by providing social marketing training and technical assistance to federally funded grantees in local communities. Several regional and state-level initiatives, including BECOMING Durham (North Carolina), Colorado's Trauma Informed System of Care, and Wraparound Orange (Florida), are underpinned by authentic collaboration with target audiences, national-level partnerships, emphasis on the stories of persons with lived experience, data collection to demonstrate efficacy, and national-level events.[188] Honest, Open, Proud is a peer-led stigma-reduction campaign based in the US that supports adults and adolescents with the decision to disclose their mental illness in different settings with the aim of effecting short-term stigma stress reduction. A recent evaluation of the program, which involved 98 individuals in an RCT, found that, at follow-up, disclosure-related distress and secrecy were significantly reduced.[189] Although these efforts demonstrate positive outcomes in terms of effecting change in public attitudes towards mental illness and people who live with it, these studies have had difficulty finding evidence of positive behavioural change in terms of destabilizing the social, economic and political inequalities that perpetuate stigma.[190]

It is important to address, given earlier emphasis on the importance of intersectionality in MHP, that anti-stigma social marketing must be more inclusive of vulnerable and/or minority groups in Canada. Social marketing campaigns have been critiqued for their neglect of diversity. As Sepali Guruge et al. write,

> *"there is very limited evidence about anti-stigma interventions that are appropriate and effective among the diverse communities in the Canadian context."*[191]

Yet these campaigns, if delivered via relevant channels and in languages other than English, can benefit newcomers and refugees, who often originate from cultures in which stigma around mental health remains disproportionately prevalent and has significant health consequences. Although mental health problems are more likely to emerge in newcomers in the year(s) after their arrival,[192] they are less likely to engage in help-seeking: they may find it challenging to navigate the Canadian system; service providers may not recognize how a newcomer's cultural background intersects with their mental health; and/or the newcomer may originate from a country with minimal mental health services.[193] In many communities, mental illnesses are a source of personal shame, and are surrounded by a culture of silence.[194] Many newcomers lack, due to the circumstances surrounding resettlement, the familial and social support for mental health[195] and may also face barriers to access, including health care policies and/or diagnostic tools and forms that

are offered only in official language(s).[ix] Yet, most social marketing efforts are English first and typically feature images of white, thin, urbane, non-disabled consumers, "which creates stereotypes about mental illness as a non-coloured issue"[196] and tend to exclude racial and linguistic minorities in Canada, including Francophone communities, from recognition and participation. Further, in leveraging social media, their reach is often restricted to those communities that have access to current technology and access to the Internet. Social marketing campaigns, if inclusive of culturally, racially, and linguistically diverse communities, have the potential to build cultures of openness and to foster dialogue about mental health among families and in communities. Furthermore, campaigns tend to target people with lived experience of mental health problems or mental illness—the 1 in 5—or those who are not affected—the 4 in 5. However, as the absence of mental illness does not imply the presence of mental health, and the absence of mental health does not imply the presence of mental illness, it is misleading to divide the population and campaign objectives along these lines. A shift in framing that, instead of splitting the population into those who live with and without mental illness, focuses on the whole population—or 5 in 5—would more closely align with the objectives of mental health promotion. In Canada, federal funding can support the expansion and enhanced inclusivity of these campaigns.

Further, as social-media-based campaigns are still relatively nascent, their effectiveness is still being established in the literature. In addition, there remains some confusion over what the approach entails, where it has been effectively applied and how it can be "adapted to significant social challenges such as changing mental health practices directed at youth and adolescents."[197] Yet, many campaigns focus on individual attitudes and behaviours over dialogues about inequality and access, which limits their capacity for transformational social change. If funded and focused, social marketing campaigns have the potential to leverage their national reach to generate a high degree of public uptake and impact.

Although anti-stigma campaigns have, owing to the proliferation of social media, grown and shown that they can influence attitudes,[198] there remains limited evidence of their impact on behaviours. Social marketing campaigns encourage people's engagement in socially desirable and respectable activities that may unintentionally overshadow the effort that is needed to transform social conditions, human rights, and economic inequities. Social marketing campaigns must buttress the goals of education and increased dialogue with meaningful, long-term social and economic inclusion of people with mental illness.[199] No such campaign alone will be effective in increasing social inclusion or eliminating discrimination; instead, they must be complemented by meaningful systemic change,[200] including effective programs, service delivery improvements, and increased access to primary care and community services. Any investment in consciousness raising or awareness building is incomplete if it does not

ix These barriers are in addition to other barriers that are adjacent to awareness/literacy, including lack of access to a family physician, lack of extended health care coverage, and perceived discrimination and differential treatment. For more on barriers to access for non-majority communities in Canada, see: Fenta, Haile, Ilene Hyman, and Samuel Noh, "Mental health service utilization by Ethiopian immigrants and refugees in Toronto," *The Journal of Nervous and Mental Disease vol. 194, no. 12 (2006): 925–934; Tiwari, Suresh K., and JianLi Wang, "Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada," Social Psychiatry and Psychiatric Epidemiology vol. 43, no. 11 (2008): 866; Kim, Giyeon, Claudia X. Aguado Loi, David A. Chiriboga, Yuri Jang, Patricia Parmelee, and Rebecca S. Allen, "Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders," Journal of Psychiatric Research vol. 45, no. 1 (2011): 104–110.*

concurrently address a series of intersecting social, political and economic trends that are making everyday life more challenging for people in Canada, impacting mental health at the individual and community levels.

RECOMMENDATION

6 Increase social spending by 2% above current levels to support social infrastructure that promotes social inclusion, freedom from violence and discrimination, access to economic opportunity and, consequently, addresses burgeoning socio-economic challenges that adversely impact individual and community mental health.

Although new initiatives and increased public awareness suggest that mental health is increasingly important to the public and decision-makers, too infrequently do efforts tangibly address the amelioration of mental health problems in relation to the social determinants of health, such as meaningful employment, social inclusion, and adequate housing. Mental health promotion implies a commitment to dealing with the challenge of reducing inequality, extending the scope of prevention such that people can cope with their circumstances. MHP efforts must address the ways in which socio-economic and political conditions intersect with and inform mental health in Canada and encourage the development of a robust mental health promotion landscape that addresses socio-economic inequities that contribute to mental health inequities.

Canada, like many other advanced economies, faces several newly accelerating socio-economic challenges that adversely impact individual and community mental health. An aging population, the technologization of social life, and a changing employment landscape[201] all generate increased stress, uncertainty, precarity and exclusion.

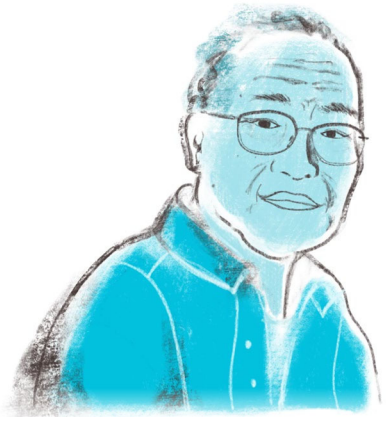
Addressing and curbing the impact of these trends is critical, as material reality has a considerable impact on individual mental health and community well-being. Unfortunately, mental health has been "abstracted from the material realities of people's lives" and the approach to mental health has been treated as one that is distinct from "questions of economic power and privilege and their relationship to the distribution of health."[202] Put another way, mental health problems or mental illnesses are often treated as intrinsic to the individual and distinct from broader socio-economic and environmental issues. This includes MHP, which provides a diverse array of interventions and initiatives but places disproportionate attention on increasing protective factors and building resilience in *individuals*; their efforts to build equitable social, economic and political environments in support of mental health are limited, likely due to funding and resourcing challenges.[203] Some researchers have found that research on MHP reinforces "an implicit assumption that stress is universal and inevitable, and therefore, the best approach is to learn how to cope with it; however, limitations of this approach, which typically focuses on individuals, include its costliness and the fact that it fails to address root causes of adversity."[204] Policy and decision-makers must not only invest more fully in mental health promotion, they must do so in a way that moves beyond individual solutions and towards a strategy that addresses the social, economic and political sources of stress and adversity, such as poverty, un- or underemployment, inequality and exclusion.[205]

An increase of 2% in social spending is necessary to address persistent challenges such as poverty. Among OECD countries, Canada remains below average on social spending. It is also imperative to direct benefits such that they meet emergent trends that are impacting older adults, underemployed persons, and youth. Yet, as much as an increase in social spending overall is vital to cultivate a strong social infrastructure, deliberations about social spending must also consider these emergent issues and allocate funds to MHP, which is well-positioned to address these issues as a complement to the other elements of the social safety net. These challenges include a growing population of older adults, the technologization of life, and precarious employment. In addition to signaling emerging priorities for social investment, these three issues signal some of the future priority areas for effort and investment in MHP.

An Aging Population

According to data from Statistics Canada, the population of older adults is growing and will continue to grow. In 2016, seniors comprised 16.9% of Canada's population; it is predicted that in 2031, nearly one in four people in Canada will be over the age of 65. Impending economic and market implications of the aging baby boomer population coincide with increasing concerns about the mental health of older adults. Age-related changes, including the loss of social roles, retirement, bereavement, and health problems all have the potential to reduce an older person's participation in social life and, by extension, their capacity to enjoy life.[206] Given the changing demographic landscape in Canada, it is of increasing importance to support the mental health of older adults in Canada.

Extensive and well-developed sociological and psychological research into the lives of older adults has focused considerably on the health impact of social disconnectedness and perceived isolation.[207] In these studies, living alone, feelings of loneliness, a diminished social network, and limited participation in social activities are all factors of isolation that contribute to poorer mental and physical health outcomes as well as higher rates of morbidity.[208] Over the past four decades, numerous studies have affirmed that loneliness is a key predictor of depression, especially among older adults.[209] In addition, ageism, including negative stereotyping of older adults, perpetuates social isolation, which would be additionally challenging for seniors who identify with marginalized groups. Considering this reality, mental health promotion and health promotion initiatives are commonly and frequently recognized as integral to meeting the mental and physical health challenges of older populations in industrialized societies.[210]



Several, high-quality guidelines and toolkits exist for the promotion of mental health in seniors.[211] While a range of programs exist for seniors, these will require greater investment to reach the growing population of seniors. It also requires investment to support the diversity of older adults, including older adults who live in long-term care or in rural/ remote areas, older adults who have lower levels of

education, older adults who live with chronic disease, older adults who are not fluent in English, and older adults who experience poverty. Crucially, the long-term effectiveness of these efforts is contingent on increased investment in addressing the specific needs of older adults, such as financial security, social inclusion, and home care to support activities of daily living.

Technology and Youth Mental Health

Social media has radically changed how we engage and understand our relationships with others. A recent study reported that 94% of people in Canada have at least one social media account, and more than 70% of social media users log on to social media at least once per day.[212] Facebook remains the leading social media platform across age groups, while youth are the predominant users of Instagram. Social media has been championed by experts across a range of fields and sectors for its ability to provide access to information, enhance social capital, offer a platform for education, and support connections between people spread across geographic and temporal borders.[213]

Yet, because social media invites such heavy and consistent use through the steady production of new content, the possibility for maladaptive or excessive use is considerable. The impact of social media use on children and youth has come into focus given youth's "evolving developmental and maturity levels and extensive exposure to these platforms"[214] alongside their unique position as "digital natives" who have no concept of pre-Internet sociality.[215]

Social media platforms trade face-to-face engagement for ongoing, screen-mediated engagement that leaves youth, its heaviest users, with little time in which they are "uncontactable."[216] In combination with individual vulnerability factors, maladaptive use can have a deleterious effect on the psychological well-being and development of children, adolescents and young adults, provoking or exacerbating psychosocial challenges, feelings of loneliness, low self-esteem, symptoms associated with depression, and a reduced sense of social connectedness.[217]

Social media has also radically changed how we understand and value ourselves. Relentless exposure to others' achievements and adventures has the potential to negatively impact the mental health of those who interact with these posts. This phenomenon has been termed "fear of missing out," or FoMo, and refers to "a pervasive apprehension that others might be having rewarding experiences from which one is absent…and a desire to stay continually connected with what others are doing."[218] Because being connected with peers is of vital importance to adolescents, those with a "low degree of basic need satisfaction…could be more tempted to engage with social media…as an easy means of staying in touch with others and participating in their lives." Yet, for many, FoMo provokes distress in the form of anxiety and feelings of inadequacy[219] because continual engagement with others' experiences may make them feel as if they do not belong and are missing out on exciting and/or shared experiences.[220]

In addition to provoking feelings of inadequacy, social media has also been linked to bullying, and a unique form of online aggression and microaggression called cyberbullying. Defined as "an aggressive, intentional act or behaviour carried out by a group or an individual, using electronic forms of contact, repeatedly and over time, against a recipient who is unable to easily defend him/herself," a recent scoping review of studies of cyberbullying found that, on average, 23% of youth reported having experienced some form of cyberbullying (e.g., unwanted sexual advances via the Internet; publicly

posted degrading comments; text harassment; account hacking).[221] Youth who have experienced cyberbullying self-report reduced self-esteem, higher rates of withdrawal, lower grades, increased rates of anxiety and depression, and weakened personal relationships.[222] Although available data do not yet demonstrate with confidence a strong association between cyberbullying and suicidality, cyberbullying via social media has been significantly associated with increased likelihood of depression.[223] Because children and youth may lack the confidence or awareness to inform adults and may not have developed coping strategies to manage their feelings, they are more likely than adults to experience harmful effects.[224]

Girls' and women's experiences on social media are contextually distinct and are in turn being understood and researched as such. The recent high-profile deaths of Audrie Pott and Rehtaeh Parsons, young women who were sexually assaulted and consequently cyberbullied, raised considerable public and legislative awareness of the relationship between social media, online harassment, and girls' safety and well-being. These cases "represent the ways that new media can [create] digital spaces wherein the perpetuation and legitimization of sexual violence takes on new qualities."[225] The distribution, or threat of distribution, of private images or images of sexual violence leaves "permanent trauma and public memory of shaming and blaming that can lead to internalization of trauma and mental health problems from self-inflicted harm behaviours as an option to cope with trauma, or suicide as the only remedy to end such trauma."[226]

Further, social media's image- and comment-saturated culture correlates with self-objectification, increased self-surveillance, and poorer body image.[227] For girls and young women, engagement with Facebook content, even for a short time, contributed to negative body image when compared to non-users.[228] Girls report that Instagram is particularly detrimental to their body images because images can be retouched and filtered either in-app or through image retouching apps like Meitu.[229] Because social media reinforces the broader socio-cultural message that women's and girls' value lies in their appearance, this informs the way that they engage in social media, sharing photos that encourage positive feedback from other users on how they look.[230]

At the same time, social media has prosocial benefits. Informed by earlier studies, which identified the social benefit of and community belonging mechanism fostered by online virtual worlds such as Second Life and massive multiplayer games such as Fortnite, recent research suggests that social media cultivates a sense of connectedness and belonging among otherwise isolated individuals.[231] It can have a positive impact in the lives of individuals living with a mental illness, as it can be productive to interact online with others who share an experience. Reported benefits include an enhanced sense of social connectedness and group belonging, which arise from sharing personal stories and coping

strategies.[232] Researchers conclude that online communities have the potential to "challenge stigma through personal empowerment and providing hope."[233] With this in mind, some policy leaders are recommending engaging with social media platforms to develop mental health centric plug-ins or addenda to their platforms to notify users when they have been connected too long and to fold mental health supports into apps.[234]

The considerable increase in the amount of research on social media in recent years demonstrates that while there are some promising applications that can promote mental health and support those living with mental health problems, social media also has concerning implications for how we communicate with each other, determine what is important, identify our passions, establish our identities and measure our worth.[235] The mental health impact of social media, as a result of bullying and/or self-objectification, to cite but two examples, strongly suggests that mental health promotion efforts must begin to address the mental health impacts of social media, help youth, and build supportive environments in which all community members are equipped to cultivate healthy personal and interpersonal relationships with social media.

The Changing Nature of Work

The rapid and dramatic shift in work arrangements in industrialized countries has also had a considerable impact on mental health in recent years. Temporary and non-standard forms of employment, which are increasingly the norm, are creating tenuous economic and professional circumstances for a growing number of people in Canada.

Although temporary and flexible work arrangements began to replace traditional employment relationships in the 1970s, [236] rapid deindustrialization in advanced economies accelerated the growth of non-standard work arrangements. Referred to as gig-based, casual, temporary, on-call, or freelancing, these short-term contracts are replacing standard employment relationships in a number of sectors such as journalism (including blogging), transportation, administration, and creative work (writing and translation, graphic and software design, photography, music).[237] Although viewed by some as a choice, this form of employment is and has long been the non-negotiable standard in some sectors, such as entertainment.[238] In the past few years, gig economy platforms and flexible work arrangements have been heavily promoted as a way for employers to provide just-in-time solutions[239] and for workers to have more or full control over their schedules.[240] For policy makers concerned with fostering economic development, the growth of gig work has generally been well received and promoted an opportunity for employers to capture top talent.[241]

What these perspectives neglect to acknowledge, however, is that the impermanent and paycheque-to-paycheque nature of unstructured employment leaves workers financially unstable, socially (and sometimes professionally) isolated,[x] unable to make long-term career plans, and forced to heavily compete for poorly paid work, without bargaining and negotiating power. Most crucially, they go without access to health and other employment benefits and are in turn forced to continue working when ill, and struggle to pay into the savings or pension funds that help them plan for the future.[242] Many gig workers are recent graduates and early-career professionals, perhaps attracted by the flexibility and app-based administration of such work.[243]

x This is particularly the case for those who have no fixed workplace and compete for work on platforms like MTurk and Upwork.

The implications of the changing nature of work extend beyond labour relations and economic considerations. Recent studies show that casual and "gig" work have a considerable impact on worker mental health and well-being. In general, individuals on short-term contracts, especially casual workers, report lower well-being than their counterparts in permanent employment.[244] A recent study of more than 2000 workers in London's gig-based music industry found that 68.5% self-reported suffering from depression and 71% self-reported suffering from anxiety, which they attribute to their work.[245] Non-standard workers who lack guidance and struggle to find gigs have reported a deterioration in their mental health, marked by feelings of failure and incompetence.[246] In addition to financial instability, workers in non-standard arrangements report being required to maintain an online presence with a strong reputation, and continually engage on social/professional networking platforms.[247] Although these efforts lead to more gigs because they build their network and earn upvotes, it also contaminates their relationships and exposes them to persistent, mentally unhealthy criticism.[248] Other studies have found that, due to the insufficient wages that gig work provides, non-standard workers work longer with greater intensity, which forces them to keep unsocial hours, creating work-home "spillover" which produces pervasive feelings of loneliness and social isolation.[249]

The mental health impact of non-standard work remains one of the hidden costs of contract work and an increasingly "gigified" economy. The purported advantages of gig work, such as flexible scheduling and the building of experience towards a permanent position, are insufficient compensation for the cost to mental health and well-being driven by isolation, precarity, and job dissatisfaction. However, mental health promotion, given its focus on community (parents, older adults), schools and workplaces, is unlikely to capture this growing population. Alongside efforts to draw in un- and underemployed persons, future investments to adapt or develop MHP programs ought to also consider the underrepresented population of gig and temporary workers in Canada.

CONCLUSION:

OPTIMIZING THE PROMISE OF MENTAL HEALTH PROMOTION

Against an increase in self-reported and diagnosed mental health problems both in Canada and in peer jurisdictions, mental health promotion has quickly become a critical strategy and approach for improving mental health in individuals and communities and for enhancing social cohesion and economic inclusion.

Recognizing the importance of introducing mental health and well-being efforts across the life course, MHP intentionally meets people where they are—in their communities, at home, in school, and at work.

Informed by a synthesis and analysis of recent academic literature, policy analysis and program evaluations of MHP programs, this paper has endeavoured to outline the current state of MHP policy-making, program effectiveness, and outcomes measurement in Canada and comparable jurisdictions, capturing the current state of and challenges facing MHP efforts and offering a policy response to these challenges as well as recommendations on future directions for MHP. It has outlined the social value and economic benefits of mental health promotion as well-demonstrated, both in Canada and in comparable jurisdictions. However, it also found that inconsistent investment in MHP in Canada means the capacity of efforts to reach non-majority populations remains limited.

The recommendations included here call for greater federal, provincial, and territorial investment in MHP that leads to a streamlined and intersectional MHP effort, underlined by a cohesive understanding of MHP, more and better data, and long-term investment to support program longevity as well as longitudinal studies to evaluate population-level and economic impact. All of this can support increased uptake of MHP as well as specialized focus that ensures MHP is evidence-informed and equipped to meet the needs of vulnerable and non-majority populations whose values and challenges have yet to be comprehensively included in MHP. It has emphasized the importance of intersectional MHP that accounts for a set of emerging socio-economic challenges across Canada.

This exploration has focused on the strengths, benefits, and impacts of MHP from an ecological or population health approach, but it has also highlighted the challenges of effective settings-based MHP, particularly in remote and ethnocultural communities. At the same time, we strongly assert that our recommendation to invest in MHP is not a recommendation to divert funds that may be earmarked for improvements in mental health services and treatment. Chronic underfunding of mental health services in Canada creates access barriers across the country but especially in rural and remote communities and for vulnerable populations.

Considering the current power inequities that accompany disparities in mental health and well-being along the lines of gender, race, sexual orientation, Indigeneity, ability, geographic location, religion, culture, socioeconomic status and age, MHP must, conceptually and practically, actively acknowledge and empower people to recognize the structural and economic inequities that create these disparities. This can only be done with a long-term vision for and investment in mental health equity for all people in Canada.

CMHA invites key stakeholders to innovate their mental health practices and look for sustainable

impacts on mental health and well-being at a population level, and encourages decision-makers in all sectors to include mental health promotion into their strategies, policies, and programs. CMHA is well-positioned to work with the federal, provincial, and territorial governments to provide research, policy and program support oriented to mental health including addictions. Across Canada, CMHA branches, regions and divisions provide a wide range of mental health and addictions services, from supportive housing to counseling and clinical services, but they also emphasize upstream interventions, offering mental health promotion programs across the life course. With branches in 330 communities across Canada, we are well-integrated into the communities that we serve and can be a strong partner in developing a National Mental Health Promotion Strategy. Such a strategy could assess mental health in all policies and identify effective programs for adaptation, implementation, evaluation and scaling up. CMHA looks forward to working with federal, provincial and territorial governments to, through evidence-informed programming, promote mental health for all people in Canada.

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APPENDIX: MHP PROGRAMS

CMHA PROGRAMS

Changing Minds (CMHA New Brunswick, CMHA National)

Target Population: Adults (18+)

Setting: Community

Languages: English

Link: https://cmhanb.ca/what-we-do/provincial-programs-initiatives/changing-minds/

Summary: Changing Minds is an innovative, multi-use mental illness education program. It was created in order to address a community need for mental health education, stigma reduction and to promote a better understanding of mental health and mental illness. The program is founded on two premises: mental illness is more challenging to understand than other kind of illness because its symptoms are changes in thinking, feeling and behaviour and we understand mental illnesses more readily when we get to know the individuals who experience them. The program consists of 8 modules, with each module containing an information component and a communication component. The information component offers basic clinical information in a presentation format followed by video stories to help create connections between theoretical knowledge and individual experience. The communication component of each module includes a reflection (personal awareness skill) and a response (an interaction skill).

Bounce Back® (CMHA Ontario; CMHA BC; CMHA Manitoba)

Target Population: Youth (15+); Adults

Setting: Community

Languages: English

Link: https://bouncebackontario.ca/

Summary: A free skill-building program designed to help adults and youth aged 15 and up to manage symptoms of anxiety and depression. This program offers free online videos to learn practical tips on managing mood, sleeping better, building confidence, increasing activity, problem solving and healthy living. BounceBack® offers an educational and motivational guided self-help program using telephone coaching and workbooks.

Living Life to the Full (CMHA Ontario; CMHA BC; CMHA Manitoba, CMHA New Brunswick; CMHA PEI, CMHA Alberta, CMHA Yukon)

Target Population: Youth (16+); Adults; Caregivers (55+)

Setting: Community

Languages: English; French; Chinese (BC)

Link: https://ontario.cmha.ca/programs-services/living-life-to-the-full/

Summary: A fun and engaging 8-week course that provides people from all walks of life with effective tools to maximize their ability to manage life's challenges. The group-based course is based on the principles of cognitive behaviour therapy (CBT) which focus on understanding how thoughts, feelings, and behaviours work together to impact well-being. Each 90-minute session focuses on a different topic, such as understanding unhelpful thoughts, engaging in enjoyable activities, coping with anger, and solving daunting problems. Living Life to the Full is intended for all ages and is available in both English and French.

Confident Parents, Thriving Kids (CMHA BC)

Target Population: Children (3-12) and their parents

Setting: Community

Languages: English

Link: https://cptka.inputhealth.com/

Summary: Through a series of 6 to 14 weekly coaching sessions, along with exercises and workbooks, trained coaches empower parents and caregivers to learn effective skills and techniques that support social skills and cooperation in their child. These techniques are proven to prevent, reduce and reverse the development of mild to moderate behaviour problems.

Road2Resilience (CMHA Nova Scotia)

Target Population: Adult (carers of children and youth)

Setting: Community

Languages: English

Link: https://novascotia.cmha.ca/initiatives/

Summary: A workshop based on the core principles of social and emotional learning: self-awareness, self-management; social awareness; relationship management; and responsible decision-making. This workshop is for those who care for or work with children and youth, and teaches participants how to model social and emotional learning skills such as problem solving, responsible decision-making, social awareness, and self-management for children and youth to help increase their interpersonal, and intrapersonal skills as well as build resilience.

Optimal Aging (CMHA Nova Scotia)

Target Population: Adults (50+)

Setting: Community

Languages: English

Link: https://novascotia.cmha.ca/events/optimal-aging-series-chester/

Summary: Optimal Aging is a 4-week mental health promotion initiative that promotes psycho-social wellness and builds resilience among individuals of age. The series provides evidence-based information on brain health and resilience tools to support factors including: 1) social activity, 2) positive thinking), 3) physical activity, 4) taking care of one's own mental health, and 5) brain challenge (thought exercises, such as learning something new), as well as health goal setting.

Mental Health Promotion and Education (CMHA Brant Haldimand Norfolk)

Target Population: Youth (16+); Adults

Setting: Community

Languages: English

Link: https://bhn.cmha.ca/mental-health-promotion-and-education/

Summary: Mental Health Promotion and Education is provided to increase awareness and understanding of mental health and mental illness, to reduce stigma, and to enhance the lives of community members in Haldimand and Norfolk. Mental Health Promotion and Education includes family initiatives, a speaker's bureau related to various mental health issues, seminars and workshops on stress management, ASIST (Applied Suicide Intervention Skills Training), and Mental Health First Aid, support groups, resource library, promotion and advocacy, forums and education responding to community needs and workplace wellness. Printed materials and resources are available.

Youth Net (CMHA Peel Dufferin)

Target Population: Youth (12–20)

Setting: Community

Languages: English

Link: https://cmhapeeldufferin.ca/programs-services/youth-net/

Summary: Youth Net offers community-based, youth-run services to support youth empowerment, awareness and access to mental health services.

Youth Wellness Program (CMHA York Region)

Target Population: Youth (12-24)

Setting: Community; School

Languages: English

Link: https://cmha-yr.on.ca/programs/youth/youth-wellness/

Summary: The Youth Wellness program offers interactive workshops and groups to school-aged youth in both classroom and community environments. The aim of the program is to enhance both teachers' and students' knowledge, attitudes and skills regarding the promotion of mental, emotional and social wellbeing. Workshops are age-appropriate and provide opportunities for students to develop healthy coping strategies, to demystify and destigmatize mental illness, and to normalize help seeking for oneself and others. Workshops include: stress and anxiety, high school 101, mental health myth-busting, suicide and depression, eating disorders.

Ma vie, c'est cool d'en parler [My Life, It's Cool to Talk About It] (CMHA Montreal)

Target Population: Youth (12-18)

Setting: School

Languages: French and English

Link: https://acsmmontreal.qc.ca/guide-dactivites-pedagogiques-ma-vie-cest-cool-den-parler/

Summary: Ma vie, c'est cool d'en parler is a pedagogical tool specifically designed to equip teenagers aged 12 to 18 years to better manage their mental health and maintain good personal balance. Intended for teachers and psychosocial service providers, the guide proposes educational activities that encourage development of personal and social skills such as self-esteem, stress management and problem solving. The activities also enable students to better understand the notion of mental health and to adopt healthy lifestyle habits.

Vieillir en Bonne Santé Mentale [Aging in Good Mental Health] (CMHA Montréal)

Target Population: Older Adults (55+)

Setting: Community

Languages: French; guide also available in English

Link: https://acsmmontreal.qc.ca/programs-services/presentation-du-programme-vieillir-en-bonne-sante-mentale/

Summary: Vieillir en Bonne Santé Mentale is a program that includes training, workshops and a guide offered by the Canadian Mental Health Association – Montréal Branch. It is a program designed for care providers, facilitators or volunteers working with seniors, and for caregivers of elderly people. The guide encourages us to reflect on our attitudes, perceptions and prejudices toward older adults, and presents reference points to enhance understanding of aging and foster respectful communication. It also provides information that clarifies difficulties related to aging and those due to psychological distress or to more serious mental disorders or cognitive impairment. The guide explores concrete ways of improving our interactions with seniors so that we can give them the best support possible and help them thrive.

Thrival Kits™ (CMHA Manitoba and Winnipeg)

Target Population: Children (9-12)

Setting: School

Languages: English

Link: https://mbwpg.cmha.ca/programs-services/school-based-youth-mental-health-promotion/

Summary: Thrival Kits™ are personal and classroom resource containers that include a variety of materials and activities designed to encourage simple, yet effective, mental health promotion strategies aimed at students in grades 4-6. There is much research to demonstrate mental health promotion as an important protective factor against mental illness. Thrival Kits™ incorporate evidence-based mental health promotion practices such as personal reflection, mindfulness meditation, stress reduction and coping strategies, and interpersonal skills development. Children are introduced to six themes that feature a variety of mental health promotion activities led by their classroom teacher. The activities are done throughout the course of a school year and are designed to help children incorporate effective coping strategies into their daily lives, strengthen their self-esteem and sense of identity, and build greater empathy and understanding of one another.

CANADIAN PROGRAMS

SNAP Model (Stop Now and Plan) (Canada)

Target Population: Children (6-12) and Youth (13-18)

Setting: School; Community (incl. child and youth camp; home)

Evaluated: Yes

Languages: English; French

Link: https://childdevelop.ca/snap/

Summary: SNAP® is an evidence-based, gender-specific, manualized, multi-component cognitive behavioural program for at-risk children aged 6 to 11 with serious disruptive behaviour concerns (aggression, rule-breaking, and conduct problems) and their families. SNAP focuses on teaching children (and their parents/caregivers) emotion regulation, self-control, and problem-solving skills with a special emphasis on challenging cognitive distortions, replacing with realistic thinking, and helping children make better choices in the moment. The goal is to improve social competencies, reducing disruptive behaviour, risk of police contact, and discipline issues while improving effective parent management skills.

Creative Retirement (Manitoba)

Target Population: Older adults (55+)

Setting: Community

Evaluated: Unknown

Languages: English

Link: https://www.creativeretirementmanitoba.ca/

Summary: Creative Retirement Manitoba is a not-for-profit education centre that contributes to the community by developing and offering innovative and interactive learning opportunities to our 55+ population. Creative Retirement presents opportunities for individuals to enrich their lives and share their knowledge and life experiences.

Have THAT Talk (Ottawa Public Health) (Ontario)

Target Population: All ages

Setting: Community; Workplace

Evaluated: Yes

Languages: English

Link: http://www.ottawapublichealth.ca/en/public-health-services/have-that-talk.aspx

Summary: This includes a mental health video series created to give parents more information about mental health. The series covers where to get help and how to talk to children and youth about mental health.

Fourth R (Western University Centre for School Mental Health) (Ontario)

Target Population: Youth (12-18)

Setting: Community; School

Evaluated: Yes

Languages: English

Link: https://youthrelationships.org/

Summary: The Fourth R is a group of researchers and professionals dedicated to promoting healthy adolescent relationships and reducing risk behaviours. It develops and evaluates programs, resources and training materials for educators and other front-line professionals who work with youth. In particular, it works with schools to promote the neglected R (for relationships) and helps build this Fourth R in school climates. Fourth R initiatives use best practice approaches to target multiple forms of violence, including bullying, dating violence, peer violence, and group violence. By building healthy school environments, Fourth R provides opportunities to engage students in developing healthy relationships and decision-making to provide a solid foundation for their learning experience.

Bounce Back and Thrive! (Ontario)

Target Population: All ages

Setting: Community

Evaluated: Yes

Languages: English

Link: http://www.reachinginreachingout.com/programs-bb&t.htm

Summary: A 10-session evolving evidence-based resiliency skills training program for parents with children under 8 years. It is designed to increase parents' capacity to provide a caring relationship and to role model resilience in their daily interactions with their children. Program components include: information exchange, hands-on activities, video clips of parents and children showing resilience-building strategies, and discussion and skills practice.

Guarding Minds at Work (Canada)

Target Population: Youth; Adults (16+)

Setting: Workplace

Evaluated: N/A

Languages: English

Link: https://www.guardingmindsatwork.ca/

Summary: Guarding Minds is a unique and free online resource to help employers - large or small, in the public or private sector - assess, protect and promote psychological health and safety in their workplaces. At the heart of Guarding Minds at Work are a survey tool and summary reports that compare your results against a 2016 nationally representative sample of workers in industries and geographical regions across Canada. Suggested strategies, planning worksheets, and evaluation resources are all provided to help you take action to improve psychological health and safety in your workplace.

INTERNATIONAL PROGRAMS

Al's Pals (US)

Target Population: Children (3-8)

Setting: School

Evaluated: Yes

Languages: English; Spanish

Link: http://wingspanworks.com/healthy-al/

Summary: Al's Pals is a resilience-based early childhood curriculum and teacher training program that develops social-emotional skills, self-control, problem-solving abilities, and healthy decision-making. It aims to help young children regulate their own feelings and behaviour, allowing educators more time for creative teaching by reducing the need for discipline; create and maintain classroom environments of caring, cooperation, respect, and responsibility; teach conflict resolution and peaceful problem-solving; promote appreciation of differences and positive social relationships; prevent and address bullying behaviour; build children's abilities to make healthy choices and cope with life's difficulties.

Triple P Parenting Program (Australia)

Target Population: All ages

Setting: Community

Evaluated: Yes

Languages: Multiple

Link: https://www.triplep.net

Summary: The Triple P Parenting Program is a prevention-based program aimed at teaching parents effective parenting strategies and fostering productive caring relationships between children and parents. The program is delivered over 8 sessions through a combination of group and individual home-based sessions. This cultural adaptation has demonstrated success in reducing problem behaviour in children and reducing reliance on dysfunctional parenting strategies among parents.

Zippy's Friends (Denmark)

Target Population: Children (5-7)

Setting: School

Evaluated: Yes

Languages: Multiple

Link: https://www.partnershipforchildren.org.uk/

Summary: Zippy's Friends aims to prevent the development of serious psychosocial problems later in life, including suicidal ideation, through expanding children's range of effective coping skills. It is designed to help all children, not just those who have difficulties or who are considered to be at risk. Zippy's Friends usually runs for 24 weeks, with one 45-minute session each week.

Act-Belong-Commit (Australia)

Target Population: All ages

Setting: Community

Evaluated: Yes

Languages: Multiple

Link: https://www.actbelongcommit.org.au/

Summary: Act-Belong-Commit is a unique, evidence-based mental health promotion program applicable to the whole community. In essence, Act-Belong-Commit aims to increase individual and community well-being by increasing and strengthening connections between community members. It encourages participation in family, cultures, community events and organisations, and increasing collaboration between community organisations that offer activities conducive to good mental health and wellbeing.

KiVa Program (Finland)

Target Population: Children (6-12)

Setting: School

Evaluated: Yes

Languages: Multiple

Link: http://www.kivaprogram.net/

Summary: An evidence-based program to prevent bullying and to tackle the cases of bullying effectively. KiVa includes both universal and indicated actions. The universal actions, such as the KiVa curriculum (student lessons and online games), are directed at all students and focus mainly on preventing bullying. The indicated actions are to be used when a bullying case has emerged. They are targeted specifically to the children and adolescents who have been involved in bullying as perpetrators or victims, as well as to classmates who are challenged to support the victim; the aim is to put an end to bullying.

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