INTEGRATING PHYSICAL AND MENTAL HEALTH PROMOTION STRATEGIES

by

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ABSTRACT

While health is defined as ‘a state of complete physical, mental and social well-being’, physical and mental health have traditionally been separated. This paper explores the question: How can physical and mental health promotion strategies be integrated and addressed simultaneously? A literature review on why physical and mental health are separated and why these two areas need to be integrated was conducted. A conceptual framework for how to integrate physical and mental health promotion strategies was developed and applied to The Obesity Reduction Strategy for British Columbia. Through this analysis, it is argued that integrating physical and mental health promotion strategies is necessary to have the greatest impact on public health.

Keywords: physical health promotion; mental health promotion; integration
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1: RATIONALE

"For far too long in Canada, we have partitioned physical and psychological health; we have severed the head from the body. This is both counterproductive and harmful." ~ M. Kirby

Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organization [WHO], 1986). And while the World Health Organization (WHO) defines health as ‘a state of complete physical, mental and social well-being’ it has been acknowledged that mental health promotion is frequently overlooked as an integral component of health promotion (Sturgeon, 2006). The promotion of mental health is increasingly being seen as a key focus in public health, and it has been recognized as the only sustainable way to reduce the social and economic burden associated with mental disorders (WHO, 2004a). Furthermore, the reciprocal relationship between physical and mental health is now widely recognized (Sturgeon, 2006). The integrating of physical health and mental health promotion strategies is necessary in order to have the greatest impact on public health. Existing models, frameworks, and strategies for integrating physical and mental health promotion are limited. As such, a conceptual framework is required to orient and drive this process, ultimately providing a tool
to inform discussion and advance the agenda for the integration of physical and mental health promotion.
2: BACKGROUND

The Ottawa Charter for Health Promotion was developed as a response to a world-wide public health movement featuring recognition that a range of factors influence health (WHO, 1986). The Ottawa Charter provides a strategic framework through five key action areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (WHO, 1986). Since its inception in 1986, the Ottawa Charter has provided direction to health promotion initiatives around the world; interestingly, mental health promotion has not traditionally been included in this framework.

The Ottawa Charter focuses attention on a systems approach recognizing that health is influenced by individual, social, political, and environmental factors; by doing so, it informs mental health promotion strategies (Jane-Llopis, Barry, Hosman, & Patel, 2005). Mental health promotion recognizes that mental health is a resource for everyday living and aims to increase psychological well-being, competence, and resilience, in addition to creating supportive communities and living conditions (WHO, 2004). Mental disorder prevention on the other hand aims to reduce the risk, incidence, prevalence, and reoccurrence of mental disorders (WHO, 2004). Prevention and promotion elements are often present within the same mental health programs and strategies, involving similar
Despite growing evidence supporting a strong interplay between physical and mental health, health-promotion initiatives continue to remain isolated (Giles & Collins, 2010). This isolation may relate to factors such as the traditional barriers between mental health and public health, the impact of stigma and discrimination associated with mental health, and the domination of the medical model in mental health. Government and organizational strategies to address ‘healthy living’ typically focus on physical activity, healthy eating, and tobacco control (BC Ministry of Health, 2007). At the same time, governments and organizations have developed separate mental health promotion strategies. Two distinct strategies have emerged, existing within silos, with a goal of increasing positive health outcomes. Failing to acknowledge the fundamental link between physical and mental health creates a significant gap in the promotion of health and healthy living.

In this paper, I will explore the question How can physical and mental health promotion strategies be integrated and addressed simultaneously? Specifically, I will examine the literature to explore why physical health and mental health promotion have traditionally been separated, citing the fact that mental health has traditionally not been considered a public health issue, and that the biomedical model that dominates the field and separates the mind and body as possible reasons. Next, I will make a case for the integration of physical and mental health promotion strategies by exploring the evidence linking physical and mental health.
and mental health. Health will be examined across a health and wellness continuum, extending from mental health promotion to prevention, treatment and maintenance (Barry, 2001). Finally, I will discuss the integration of physical and mental health promotion strategies through the development of a conceptual framework and then demonstrate the use of the framework using The BC Obesity Reduction Strategy as a case study. Policy and practice implications will also be considered.
3: METHODS

To explore and answer the question of interest, a critical literature review was conducted. Specifically, scholarly articles were reviewed to provide knowledge about the fields of physical and mental health promotion and current research findings. The articles were obtained using scholarly databases (e.g. Medline, PsychINFO, Web of Science). Key search terms used were ‘mental health promotion’, ‘physical health promotion’, and ‘public health’. Approximately two dozen articles on mental health promotion in public health were reviewed. Article selection was then refined to include research with a particular focus on the integration of physical and mental health promotion in public health. Given a very limited body of knowledge on integrated strategies, all relevant literature available (approximately a dozen articles) was reviewed; two of these articles specifically addressed the issue of how to integrate physical and mental health promotion, while the others supported an argument for the integration of these two areas. Additionally, key government and organization documents and reports were examined to provide a practice based context. Two seminal reports by the WHO on mental disorder prevention and mental health promotion were also examined (WHO, 2004; WHO, 2004a). Government documents reviewed were specific to the province of British Columbia, and included model core program and evidence review papers from the Core Public Health Functions for BC (BC Ministry of Health, 2007).
A thematic approach was used to analyze the literature. I was interested in exploring and analyzing the themes that emerged from the literature to explain why mental and physical health have been kept separate and support the argument for why these two fields need to be properly integrated.

The literature review revealed an absence of models and frameworks for the integration of physical and mental health promotion strategies. The limited models presented in the literature were minimal in scope, and demonstrated a need to develop a conceptual framework for the integration of physical and mental health promotion strategies.

The conceptual framework presented in this paper builds upon the Centre for Disease Control’s Logic Model for the Integration of Mental Health into Chronic Disease Prevention and Health Promotion (Lando, Williams, Williams, & Sturgis, 2006), as seen in Appendix A, the BC Healthy Living Core Model Program (BC Ministry of Health, 2007), and the Framework for Core Functions in Public Health (BC Ministry of Healthy Living and Sport, 2009), as seen in Appendix B. These documents were reviewed and selected for their valuable contribution to the integration of physical and mental health promotion.

The Centre for Disease Control’s Logic Model emerged from a “Mind the Body” meeting that took place to discuss how to better integrate mental health into disease prevention programs at the CDC (Lando, Williams, Williams, & Sturgis, 2006). This logic model provides detailed information on inputs, activities, and desired outcomes for addressing mental health and chronic disease prevention, and was used as a starting point for the integration
discussion. Key elements of this logic model informed the development of the conceptual model presented in this paper.

The BC Healthy Living Core Model Program identifies three key priorities – physical activity, healthy eating, and a smoke-free lifestyle – for healthy living programs in BC (BC Ministry of Health, 2007). This document discusses the integration of all three key priority areas; these approaches to integration were used in the conceptual framework to integrate physical and mental health.

The Core Functions for BC Framework is a directional document with a focus on renewing and strengthening public health in BC. A framework is provided to help improve the population health of British Columbians; a ‘population and inequities lens’ component of this framework ensures that all programs and policies are developed and implemented with a population and inequities approach. The application of a ‘lens’ to the conceptual framework in this paper was based on the work of the Core Functions for BC Framework.

A review of the Organizing Framework and progress reports by the Provincial Health Services Authority (PHSA) provided background information on the Obesity Reduction Strategy for BC used for the case study (Provincial Health Services Authority, 2009).
4: LITERATURE REVIEW

Key themes emerged from the literature review to explain why physical and mental health have been separated and why physical and mental health promotion strategies need to be integrated. It is important to note that the literature was reviewed using Western understandings and definitions of health. As such, the emergent themes presented in the literature review are based on Western conceptions of health and mental health and do not take into consideration various cultural beliefs surrounding health.

Four recurrent themes from the literature help to explain why physical and mental health have been kept separate. These themes include mental health not traditionally being a part of public health and therefore not included in health promotion, the issue of stigma and discrimination, the medical model domination in the mental health field, and current funding models and mandates.

The argument for integrating physical and mental health promotion strategies is supported by evidence demonstrating the shared determinants of physical and mental health, increased research demonstrating the absolute link between physical and mental health (providing context for linking physical and mental health by understanding health along a continuum) and the advantages of sharing resources.
4.1 Why Physical Health and Mental Health Have Been Kept Separate

Physical health promotion strategies are just one component of public health. A public health approach expands beyond disease diagnosis and treatment, and includes the epidemiologic surveillance of the health of a population, health promotion, disease prevention, and access to and evaluation of services (United States Department of Health and Human Services [USDHHS], 1999). The field of mental health has typically been focused on mental illness, and it is only within the past 10 years that the scope has broadened to include a focus on disease prevention and health promotion (USDHHS, 1999). This breadth has developed as treatment for mental disorders has shifted from specialty care to primary care and as a more integrated approach to care has been promoted across a continuum from health promotion to prevention to early intervention to treatment to support and recovery (USDHHS, 1999). As a result, mental health and illness has not traditionally played a role in the field of public health, and therefore has not been included in physical health promotion (WHO, 2004a). Furthermore, the body of knowledge, in addition to surveillance and epidemiologic data, is considerably larger for mental illness than it is for mental disorder prevention and even less for mental health promotion; the sheer lack of information and data is a factor that perpetuates the separation of mental health and public health (Satcher & Druss, 2010; USDHHS, 1999).
The literature clearly states that the only sustainable way to manage the burden of mental health and illness is through a public health approach (USDHHS, 1999; WHO, 2004; Sturgeon, 2006). Increasingly, public health agencies and organizations have developed strategies and initiatives targeted towards mental health promotion, such as the Public Health Agency of Canada’s Mental Health Strategy or the BC Core Functions Mental Health Promotion Model Core Programs. However, there is still great concern that the fields of mental health and public health remain isolated, as evidenced through distinct and disconnected chronic disease prevention, physical health promotion and mental health promotion strategies (Giles & Collins, 2010).

The issue of stigma, and the stigmatization and discrimination of people with mental disorders, is another reason why mental health and physical health have remained separate. Stigma and discrimination have a substantial impact on the individual, and those with mental disorders often report that stigma has as much, or more, of an impact than the illness itself (Hocking, 2003). It has been suggested that, in part, stigma stems from the artificial divisions of mind and body, as well as the traditional separation between the mental health treatment system and the mainstream health system (USDHHS, 1999; Herrman, 2001). Historically, people with mental illness were institutionalized in asylums, and it was not until the 1950s that the deinstitutionalization movement occurred and care shifted to the community (USDHHS, 1999). Unlike physical disorders, part of the stigma associated with mental disorders is related to the common belief that they are not preventable and in many instances non-treatable (Herrman,
Further, the stigma associated with mental disorders is not present for the majority of physical health disorders. It has been suggested that when integrating mental health promotion activities with health promotion, advocacy for mental health (including reducing stigma) should be retained as a distinct strategy (Herrman & Jane-Llopis, 2005).

Associated with issues of stigma, the area of mental health is often neglected because of confusion about how to understand and define mental health and uncertainty about treating and preventing mental disorders (Herrman, 2001; Herrman & Jane-Llopis, 2005). Additionally, mental health has different meanings depending on setting, culture, socioeconomic and political influences (WHO, 2004a). Herrman (2001) suggests that barriers to understanding and defining mental health include the belief that either mental or physical health can exist alone, and that mental illness and mental health are mutually exclusive. Furthermore, mental health is often associated with ‘mental illness’ rather than a basic human right and a resource for everyday living (GermAnn, & Ardiles, 2008). The ambiguity surrounding mental health and illness has contributed to its low priority within governments and organizations, and an overall neglect of mental health promotion (Herrman, 2001).

As previously mentioned, the field of mental health has typically focused on mental illness and has been treatment focused; the medical model has dominated the field of mental health and illness. Mittlemark (2005) explains that there are often two groups within the mental health field. The larger group is medically oriented and dominated by numbers and types of facilities, psychiatry’s
drive for expansion, and mortality, morbidity, and disability statistics, among other things. The smaller group is community-health oriented and focused on mental health promotion for the entire population (Mittlemark, 2005). These distinct groups often compete for resources. Our conceptualization of the epidemiology related to disease contributes to the disease-focused problem, and the dominance of illness care in the mental health field additionally contributes to this challenge. As such, the medical and treatment focus in mental health has contributed to a lack of focus on mental health promotion.

Further exacerbating the divide between physical and mental health promotion is the tendency for government and organizational initiatives to separate physical and mental health promotion strategies. For example, the Core Public Health Functions for BC has a core model program for Healthy Living, with a focus on healthy eating, physical activity, and tobacco control, and a core model program for Mental Health Promotion (in addition to mental disorder prevention), which focuses on how to promote good mental health across the lifespan (BC Ministry of Health, 2007; BC Ministry of Healthy Living & Sport, 2009). The Healthy Living document does not include mental health, and the Mental Health Promotion document does not readily include physical health. These documents, while providing guidance for health promotion initiatives, do not encourage an integrated health promotion strategy including both physical and mental health. Additionally, funding models and the varying mandates for different organizations are not conducive to integration. For example, different ministries within the government of BC, such as the Ministry of Child and Family
Development, the Ministry of Health Services, and the Ministry of Healthy Living and Sport may provide funding for health promotion (physical or mental) initiatives, but barriers are created by the distinct ministry mandates and funding models, making it difficult to integrate strategies. A funding model requiring integration of physical and mental health promotion would be more conducive to integration.

4.2 Why Physical and Mental Health Promotion Need to be Integrated

An increased awareness and acknowledgement of the intimate connection between physical and mental health has been noted in recent years; mental well-being is a protective factor for physical health, and good physical health impacts positively on mental health (Sturgeon, 2006; WHO, 2004a). Despite the WHO defining health as “a state of complete physical, mental and social well-being” (WHO, 2004), and various cultures assuming integrated views of health, understanding that mental health and physical health are reciprocal is not implicit to most (Herrman & Jane-Llopis, 2005). It has also been acknowledged that physical health and mental health share many of the same determinants and thus focusing on the shared determinants will benefit all aspects of health (Sturgeon, 2006).

As research continues to expand, a greater understanding of the connections between physical and mental health will be achieved. Co morbidity, behavioural, and lifestyle factors are a few of the mechanisms that connect these
two areas (Williams, Saxena, & McQueen, 2005). For example, tobacco use among people with a mental disorder is approximately twice that of the general population (Lasser et al., 2000), and after a heart attack 1 in 3 patients exhibit depressive symptoms (Giles & Collins, 2010). Research clearly demonstrates that young people with depression and low self esteem are linked with smoking, binge drinking, eating disorders, and unsafe sex (Patton et al., 1998), and diabetes, cancer, cardiovascular disease, and HIV/AIDS affect and have been linked to the mental state of individuals (Sturgeon, 2006). Additionally, an individual’s ability to undertake health-promoting behaviours can be adversely affected by the presence of a mental disorder, such as depression or anxiety (Lando, Williams, Williams, & Sturgis, 2006). Research also demonstrates that an individual’s ability to participate in treatment and to recover from a chronic disease is influenced by mental health status, and that the mental well-being of family members and caregivers is impacted, and as a result, they may neglect their own physical health (Lando, Williams, Williams, & Sturgis, 2006).

Understanding health and illness along a continuum instead of mutually exclusive of each other, provides a context for linking physical and mental health. For example, eating disorders and obesity can be located along a continuum of weight and shape related problems (Neumark-Sztainer & Hannan, 2000). Regardless of whether we are referring to mental or physical health, simply looking at health and illness as exclusive entities ultimately places the emphasis on intervention and treatment, instead of taking a strengths based promotion focus (Herrman & Jane-Llopis, 2005). Isolating mental health from mental illness
fails to acknowledge that these two states are fundamentally linked. Similarly, isolating mental health from physical health (or mental illness from physical illness) fails to acknowledge that these two functions are inseparable (USDHHS, 1999). If health and illness, both mentally and physically, are understood as existing along a continuum, the value of integrating these areas must not be denied.

With public health receiving only 3% of the provincial health budget, resources for physical health and mental health promotion are scarce (The Select Standing Committee on Health, 2006). Integrating physical and mental health promotion is one way to share resources and build capacity. Multi-component interventions that target the generic determinants of physical and mental health can have multiple benefits in cases where resources are scarce (Herrman & Jane-Llopis, 2005). Combining mental and physical health strategies has the potential to have positive health, social, and economic outcomes, and to contribute to significant savings on resources (WHO, 2004). Conceptually and practically, integration is important because it allows for the development of more comprehensive programs and policies; duplication of health promotion strategies is limited, collaboration is enhanced, and multiple outcomes are achieved.

The relationship between mental and physical health, in addition to their multiple determinants, requires a multi-sectoral public health approach (WHO, 2004). While numerous documents and programs speak to the importance of coordinating across other sectors and programs, these strategies are often not integrated in any meaningful way. Addressing physical and mental health
simultaneously provides a unique opportunity to work collaboratively with the goal of improving numerous health outcomes.
5: DISCUSSION

5.1 Overview

Physical and mental health are fundamentally linked. As such, it is essential that health promotion initiatives, which target ‘healthy living’, integrate both physical and mental health promoting indicators, activities, and outcomes. The term integration refers to the bringing together of elements or components that were formerly separated (Kodner & Spreeuwenberg, 2002). Rooted in systems theory, integration supports co-operation and collaboration among and between various parts of a system (or organization), enabling it to achieve common goals and favourable results (Kodner & Spreeuwenberg, 2002).

5.2 Conceptual Framework

In an attempt to further the goal of the integration of physical and mental health promotion initiatives, a conceptual framework has been developed which builds on previous work in physical and mental health promotion. This framework can be viewed in Appendix C. The components of the framework are described below.

5.2.1 Integration Approaches

The groundwork of integrating physical and mental health promotion can be facilitated using three key methods. Regional and community organizational initiatives allow for integration opportunities by enhancing initiatives in progress
and include both internal and external priorities and structures (BC Ministry of Health, 2007). For example, an initiative aimed at increasing physical activity may provide a vehicle to integrating mental health promotion programming to achieve improved results. As the BC Ministry of Health (2007) states, integration at the organizational level must consider internal structures, such as management responsibility for integration or establishing policies that support integration, in addition to external partnerships that support collaboration among various stakeholders.

Integration may also be approached through regional and community key target populations. Targeting specific populations allows for the unique needs, settings, and circumstances of different groups to be addressed. As public health programs are often targeted towards specific at-risk populations, one approach is to integrate both physical and mental health promotion initiatives into existing public health programs, such as early childhood programs or poverty reduction strategies. Target populations, such as adolescents or Aboriginal people, may also provide vehicles for stand-alone programs that integrate physical and mental health promotion initiatives.

Finally, the integration of physical and mental health in key settings provides another strategy. The settings approach has been demonstrated as an effective way to organize and deliver public health programming (BC Ministry of Health, 2007). Homes, schools, workplaces, and the community are commonly used settings for implementing programs. Integrating physical and mental health promotion in the workplace for example, may include stress-reduction programs,
healthy eating campaigns, and fitness center subsidies. Multi-sectoral, comprehensive approaches at the settings level have been shown to be particularly effective and help to support the integration of objectives (BC Ministry of Health, 2007).

5.2.2 Foundations for Integration

The foundations for integration provide a number of key components necessary to facilitate effective integration of physical and mental health promotion activities. Surveillance, measures, and indicators are important for collecting data and enhancing existing systems. Current surveillance systems tend to separate physical and mental health indicators and only recently have begun to measure the interaction between the two (Lando, Williams, Williams, & Sturgis, 2006). Measures and indicators are directly linked to evaluation, research, and evidence based practices and policies. Completing evaluations on integrated programs where appropriate indicators are being measured provides the evidence required to determine the effectiveness of a program or policy, and in turn will affect future programming and evidence. Further, measurements, surveillance, and evaluations have the ability to inform research in the area of integrated physical and mental health promotion. The conceptual framework also includes partnerships and collaborations as a key foundation for integration. Cross-sectoral partnerships and collaborations are necessary for all public health programs, but are particularly important for integrating physical and mental health, as these two fields typically see themselves as distinct. System capacity and inputs are also essential for successful integration; having management
positions specific to overseeing integration can provide the necessary support. As previously mentioned, physical and mental health share similar determinants. It is therefore important to tackle these determinants as a way to address issues further downstream. The foundations for integration are connected through a feedback loop; each foundation affects the others, and as one changes it influences the others.

5.2.3 Advocacy for Mental Health and Stigma Reduction

Advocacy for mental health and stigma reduction must remain a distinctive approach during the process and in the maintenance of integration. The conceptual framework uses an advocacy and stigma reduction lens to ensure that all activities and programming incorporate strategies that reduce the stigma associated with mental health. Efforts to bring mental health promotion into mainstream health promotion require that advocacy remain a distinct strategy (Herrman & Llopis, 2005).

5.3 Case Study: The Obesity Reduction Strategy for British Columbia

5.3.1 Overview

In April 2009 the BC Health Officers Council made a unanimous decision to develop a comprehensive obesity reduction strategy (ORS) for British Columbia. The Provincial Health Services Authority Centres for Population & Public Health (PHSA – CPPH) has been designated as the lead for the ORS and
in June 2009, the Provincial Obesity Task Force was formed. The goals of the task force are: (1) to develop an Obesity Reduction Strategy for BC emphasizing engagement and mobilizing a broad range of partners, and (2) the mobilization of resources across all sectors to implement the strategy (Provincial Health Services Authority [PHSA], 2009). An extensive review of the literature on ‘best practice’ prevention and treatment interventions for obesity has been conducted, and a framework for organizing the process of building the ORS has been completed. As of January 2010, four working groups have been established to develop the ORS and a forum will be held in April 2010 to review recommendations and confirm key components of the strategy (PHSA, 2009).

5.3.2 Analyzing the Obesity Reduction Strategy for BC through the Conceptual Framework for Integrating Physical and Mental Health Promotion

The ORS for BC takes a public health approach to address the issue of obesity. Built around multi-sector, multi-stakeholder provincial and community level collaborations, the strategy has been organized around four working groups: food & healthy eating, physical activity, treatment & management, and data, evaluation and research. The ORS strives to adopt a life course approach and focuses initiatives in the societal, organizational, community, and home setting. In an attempt to achieve greater equity and recognize diversity, cross-cutting lenses of socio-economic status, gender, race, culture, ethnicity, language, sexuality, differential abilities, and mental health status have been included.
While research on the relationship between mental health and obesity is limited and conflicting due to methodological differences among studies, general trends show a statistically significant association between obesity and depressive disorders, and obesity and anxiety disorders (Scott et al., 2008). Sociodemographic variables are important in this body of literature, with research showing obesity and depressive and anxiety disorders having a stronger association in females than males (Simon et al., 2006). Research suggests that obesity is associated with a 24% increase in the probability of mood and anxiety disorders (Simon et al., 2006), and obesity is associated with major depressive disorder in females (McElroy et al., 2004). Research has shown significantly higher prevalence rates for psychiatric disorders in obese children and youth (Janicke, Harman, Kelleher, & Zhang, 2008). Further, Talen & Mann (2009) argue that mental health factors contribute to the onset and maintenance of overweight and obese status, with body image, self-esteem, mood disorders, and social and family factors contributing to the problem.

While the ORS includes a mental health status lens, no further reference to mental health is evident in the strategy. A traditional approach to obesity has been taken, separating physical activity, food & healthy eating, and management and treatment components; the fundamental impact of mental health has not been incorporated. Using a mental health status lens is a step in the right direction, but it is not sufficient for the support of mental health promotion and mental disorder prevention initiatives equally alongside activities to promote healthy eating and physical activity. With strong evidence to
demonstrate the reciprocal relationship between physical and mental health, the question needs to be asked: How can mental health promotion and mental disorder prevention be integrated into the Obesity Reduction Strategy for BC?

The conceptual framework for integrating physical and mental health promotion provides a number of opportunities for integration into the ORS. One possibility is to integrate mental health through the organizing initiatives of the ORS. In this case, the food & healthy eating, physical activity, and management and treatment working groups can serve as vehicles for integrating mental health promotion and mental disorder prevention initiatives. For example, the food & healthy eating working group could include eating disorder prevention programming at both the primary and secondary prevention level into their `healthy eating' strategy. Consistent with the ORS recognizing diversity in the BC population, mental health promotion and mental disorder prevention initiatives can also be integrated into key target populations. For example, healthy eating, physical activity, and management and treatment interventions focusing on immigrant and minority populations could also include screening for high prevalence mental disorders in the population. Other mental health issues common to this group, such as isolation, could be addressed through mental health promotion activities that promote community engagement and coping skills. Finally, bringing together mental and physical health in the identified community setting provides further opportunity for integration. For example, building on current physical activity programs in schools, the ORS could
incorporate self-esteem and social skills programming to further enhance the promotion of health.

With a strong existing foundation built upon multi-sector partnerships and collaboration, the ORS is in an ideal position to actively engage the mental health sector. As a part of the conceptual framework for integration presented in this paper, partnerships and collaboration play an integral role for the successful integration of physical and mental health promotion strategies; unique to the ORS is that many sectors are exposed to the mental health field that otherwise would not be. The ORS also acknowledges that obesity expands beyond personal life choices to greater societal influences, thus addressing the social determinants of the disease. This presents a unique opportunity to tackle the determinants of mental health, many of which are shared with physical health and obesity. One of the goals of the task force is to mobilize resources across all sectors to implement the ORS. As previously mentioned, sharing resources between physical and mental health through multi-component interventions can have benefits for cases where resources are scarce; bringing in additional mental health resources will help to provide the necessary focus to impact the health of all British Columbians. Finally, integrating mental health into the ORS provides an opportunity for stigma reduction and mental health advocacy. Mental disorders are often believed to be untreatable and not preventable; incorporating mental health into an obesity strategy may help to ‘mainstream’ mental health promotion initiatives. By doing so, we may be able to shift towards
supporting mental health and well-being as an integral part of health across the
population.

5.3.3 Recommendations for the Obesity Reduction Strategy to Integrate Mental Health Promotion

It is imperative that the ORS for BC acknowledge that mental health promotion improves physical health and that mental health cannot be isolated from physical health. The following recommendations are provided to support the integration of mental health promotion and mental disorder prevention into the obesity reduction strategy.

- **Leadership and Innovation** - It is recommended that the ORS acknowledge the fundamental link between physical and mental health and make a commitment to include mental health promotion and mental disease prevention initiatives as a key feature of the strategy. Integrating a continuum of mental health across the work of the obesity reduction strategy will contribute to advocacy for mental health and facilitate the integration of mental and physical health while providing innovation and leadership in the field of health promotion and disease prevention.

- **System Capacity and Inputs** – It is recommended that the ORS include representation from mental health on the ORS Task Force in addition to each of the four working groups. This will ensure that
mental health is incorporated into each of the working group strategies. Specific attention should be paid to the management and treatment working group as a vehicle for mental disorder prevention associated with obesity and other health related problems. Furthermore, allocating resources for a position to oversee the integration process is critical for ensuring success.

- **Surveillance, Indicators, and Evaluation** – It is recommended that the Data, Evaluation, and Research working group of the ORS utilize and/or develop indicators that measure physical and mental health as a function of each other. This will help to further our understanding of the connection between physical and mental health, and provide information on the effectiveness of integrating health promotion strategies.

### 5.4 Challenges of Integration

The most significant barrier to integrating physical and mental health is moving beyond traditional approaches to health promotion. Not only must mental health promotion become a fundamental part of public health, but two areas that have not generally been linked must now collaboratively work together; undoubtedly there will be resistance to overcome. While substantial research exists to support the interconnectedness between physical and mental health, this area of research is still evolving, and further work, specifically in the effectiveness of integrated approaches is needed.
Another challenge will be the implementation of changes at the system level, including funding models and mandates for government and organizational initiatives. As previously mentioned, existing funding models and varying mandates for different organizations are not conducive to integration. Making modifications that address funding and support collaboration across organizations while acknowledging individual mandates will be challenging. One possible way to address this challenge is for governments to commit to funding specifically for initiatives that integrate physical and mental health promotion.

Addressing the barriers associated with varying professional cultures will also be a challenge. While Mittlemark (2005) discusses the challenges of varying professional cultures, priorities, and concepts within the mental health field itself, there is also a barrier that extends outside the mental health field and will inevitably be present as mental and physical health promotion integrate. Every profession has a different set of beliefs, attitudes, customs, and behaviours that shape its culture (Hall, 2005); each profession brings to the table unique beliefs and attitudes about health, mental health, and what it means to promote ‘health’. The different language and concepts used by the diversity of professionals in public health means that a common language and understanding must first be established before proceeding.

Finally, the stigma and discrimination associated with mental health disorders will be a barrier to overcome. Advocacy for mental health is critical for integrated strategies and must not be overlooked. Shifting towards a strengths-
based mental wellness model will also prove to be a challenge, as so much of mental health is based on disorders and illness care.

5.5 Implications for Policy and Practice

The integration of physical and mental health promotion strategies will undoubtedly have numerous implications at many levels of policy and practice. At the level of front line workers, education about the interconnected relationship between physical and mental health and the objectives of integration is critical. For example, chronic disease prevention workers need to be educated on mental health promotion and mental health workers need to be educated on physical health promotion so that both aspects of health are fully supported and fostered. Examining implications at the program level, strong communication, collaboration, and partnerships between physical and mental health are critical; programming must be conducted with both groups (having equal power) at the table and include relevant and rigorous evaluation. Furthermore, funding models must shift to support integrated initiatives instead of isolated strategies. The development of specific evidence-based policy to oversee the integration of physical and mental health and its implementation is necessary, in addition to involving broader social policies that address shared determinants. Further research needs to be conducted with a focus specifically on the effectiveness of integrating physical and mental health promotion strategies, and the necessary tools for further development that measure physical and mental health as a function of each other.
6: CONCLUSION

This paper argues that integrating physical and mental health promotion strategies is necessary in order to have the greatest impact on public health. Physical and mental health promotion strategies have traditionally been separated and mental health has not been seen as a part of public health. The focus on mental illness and a lack of research and data on mental health promotion contribute to the situation. However, increasing information is available on the reciprocal relationship between physical and mental health and their shared determinants.

The integration of physical and mental health strategies can be advanced through numerous approaches, and a conceptual framework has been presented in this context to further this discussion. The current Obesity Reduction Strategy for BC provides an excellent opportunity for providing leadership and innovation in integrating physical and mental health initiatives and it is important for mental health to not be overlooked in this strategy. Further research on integrating physical and mental health promotion strategies, in addition to their effectiveness is needed.
APPENDIX A: LOGIC MODEL FOR THE INTEGRATION OF MENTAL HEALTH INTO CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Lando, Williams, Williams, & Sturgis, 2006
APPENDIX B: FRAMEWORK FOR CORE FUNCTIONS IN PUBLIC HEALTH

CORE FUNCTIONS FRAMEWORK

Health Promotion
- Develop healthy public policy; advocate/create supportive environments; strengthen communities; develop personal skills; build partnerships

Health Protection
- Legislate, Regulate, Tax, Inspect, Enforce, Punish

Preventive Interventions
- Immunize, Screen, Counsel, Support, behaviour change, Treat

Health Assessment & Disease Surveillance
- Public health, epidemiology, clinical epidemiology, health lab networks, analysis and dissemination

Health Improvement
- Programs that work to reduce a wide range of health problems: include a focus on reproductive health, healthy development, creation of healthy communities, enabling adoption of healthy patterns of living, food security, and promotion of mental health

Disease, Injury, & Disability Prevention
- Programs that focus on specific diseases, disabilities, and injuries that constitute a significant burden of disease (e.g., chronic diseases, injuries, mental health problems, addictions, communicable diseases)

Environmental Health
- Programs that work to protect people from environmental hazards, both from natural causes and human activity (e.g., clean water and air, safe food, community sanitation, and environmental health)

Health Emergency Management
- Programs that ensure the public health sector is fully prepared and able to respond effectively to severe outbreaks of communicable disease, natural or human-induced disasters, major accidents, terrorism, etc.

Population & Inequalities Lens

System Capacity
- Health information systems and quality management capacity

BC Ministry of Health Services, 2005
APPENDIX C: CONCEPTUAL FRAMEWORK FOR THE INTEGRATION OF PHYSICAL AND MENTAL HEALTH PROMOTION STRATEGIES

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Advocacy for Mental Health and Stigma Reduction
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