EXAMINATION OF CURRENT AWARENESS AND UNDERSTANDING OF MENTAL HEALTH PROMOTION AMONG TERTIARY CARE PROVIDERS

By

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B.Sc., University of British Columbia, 2005

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ABSTRACT

Mental health is an integral component and determinant of health. Mental health promotion (MHP) is a key primordial and primary preventive strategy that aims to enhance the capacity of individuals and communities to take control over their lives and improve their mental health and wellbeing. Development of mental health promoting healthcare systems is essential to promoting the mental wellbeing of a population and is dependent on having a skilled and informed workforce. This paper examines current awareness and understanding of MHP among tertiary care providers. Results showed that participants understood the relationship between mental and physical health, and the individual and social level factors that determine one's mental health. Participants exhibited minimal understanding of the societal and economic determinants of health, and of MHP. It is recommended that MHP education and training resources be developed for tertiary care providers to effectively incorporate MHP into tertiary care services.

Keywords: mental health promotion; determinants of health; positive mental health; flourishing; tertiary care; mental health promoting healthcare systems

DEDICATION

I dedicate this paper to the amazing people in my life who have supported me through this journey. First to my parents, Chris and Claire, who have supported and encouraged me every step of the way. I would not be where I am today without the two of you by my side, as my parents and as my friends. Secondly, to my incredible twin sister for her unconditional love and support. Alexa, you are not only my twin sister but also my best friend and ally in life. I also dedicate this paper to my sister Rebecca, for her love, support, encouragement, strength and unwavering belief in me. You have helped me overcome every obstacle that has been put in front of me and I am truly grateful for that. To my best friend, Katie. There are no words to express how extremely grateful I am to have you in my life. Thank you for your continued love, support, patience, understanding and guidance through this journey. I am forever indebted to you. Lastly, to the best friends a girl can ever have, Sam, Delara, and Meghan. For your continued love, support and encouragement to keep on going. Thank you.

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BACKGROUND

Mental health is a vital component for overall health, wellbeing and effective functioning of an individual, community and society. The World Health Organization (WHO) defines mental health as a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (World Health Organization, [WHO], 2007). Mental health is more than the absence of mental illness; it is the presence of a positive sense of emotional, social, intellectual, and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity (BC Ministry of Health, [BC MoH], 2007a; BC MoH, 2007b; GermAnn & Ardiles, 2009; Joubert & Raeburn, 1997).

Mental illness refers to a collection of diagnosable mental disorders that result from biological, developmental and/or psychosocial factors (BC MoH, 2007a; United States Surgeon General, 1999). Mental disorders are health conditions characterized by significant impairment of an individual’s cognitive, affective, or relational abilities (BC MoH, 2007a). Mental health problems refer to signs and symptoms of less intensity, severity, or shorter duration than mental illness and disorders and often occur in response to life stressors (Barry & Jenkins, 2006; BC MoH, 2007a; Commonwealth Department of Health and Aged Care, [CDHAC], 2000; GermAnn & Ardiles, 2009; United States Surgeon General, 1999).

Mental health promotion (MHP) is a process of enabling individuals and communities to take control over their own lives and to achieve and maintain positive mental health and quality of life (Barry & Jenkins, 2006; BC MoH, 2007a; BC MoH, 2070b; Jané-Llopis, Barry, Hosman, & Patel, 2005; Keleher & Armstrong, 2006). MHP is based on the fundamental health promotion principles of the Ottawa Charter of Health Promotion (Barry, 2007; Jané-Llopis, et al., 2005). The Ottawa Charter of Health Promotion principles include building healthy public policy; creating supportive environments; strengthening community capacity; reorienting health services; and developing personal skills (WHO, 1986).

MHP is not about the prevention of mental illness or disorders. The difference between MHP and mental illness prevention (MIP) lies within their targeted outcomes (BC MoH, 2007b). MIP focuses on mental illness. It seeks to reduce the symptoms, and ultimately the incidence and prevalence of mental illnesses. Conversely, MHP focuses on mental health. MHP seeks to promote a positive state of mental health by increasing and strengthening psychological wellbeing, competence and resilience; strengthening protective factors for enhancing wellbeing and quality of life; and creating stronger, healthier and supportive conditions and environments (BC MoH, 2007b; Saxena, Jané-Llopis & Hosman, 2006). MHP also differs from MIP, as it focuses on the population as a whole rather than on people at risk for mental illnesses (Barry & Jenkins, 2006; BC MoH, 2007b; European Commission, 2008; GermAnn & Ardiles, 2009; Jané-Llopis, et al., 2005).

MHP seeks to influence the multiple social, psychological, biological, economic and environmental protective and risk factors that affect the mental health of

individuals, communities and populations (Barry & Jenkins, 2006; BC MoH, 2007a; Desjarlais, Kleinman, Eisenberg & Good, 1995; Herrman & Jané-Llopis, 2005; Hosman & Jané-Llopis, 1999; Marmot and Wilkinson, 1999; Mrazek and Haggerty, 1994; WHO, 2004a). Risk factors are those factors that increase the likelihood that an individual will develop mental health disorders (Table 1). Risk factors can also worsen existing mental health disorders (Barry & Jenkins, 2006; BC MoH, 2007a; Centre for Addictions & Mental Health, [CAMH], 2005; CDHAC, 2000; Mrazek & Haggerty, 1994). Protective factors are those factors that prevent, moderate and mitigate the effects of risk factors thereby reducing the risk and severity of mental illness and increasing the likelihood of positive mental health (Table 2) (Barry & Jenkins, 2006; BC MoH, 2007a; GermAnn & Ardiles, 2009; Loxley, et al., 2004; Moodie & Jenkins, 2005; Pollett, 2007).

Table 1 Risk Factors

RISK FACTORS			
Psychological • Academic failure and scholastic demoralization • Attention deficits • Communication deviance • Emotional immaturity and dyscontrol • Excessive substance use • Loneliness • Sensory disabilities or organic handicaps • Social Incompetence • Low self-esteem • Poor coping skills • Insecure attachment in childhood • Social incompetence	**Biological** • Chronic insomnia • Chronic pain • Early pregnancies • Genetic risk factors • Low birth weight • Medical illness • Neurochemical imbalance • Perinatal complications • Sex **Structural** • Lack of education, transportation, housing • Poverty • Homelessness • Stigma and discrimination (e.g. racism, sexism)	**Social** • Displacement • Social isolation and alienation • Neighbourhood disorganization • Poor work skills & habits • Reading disabilities • Peer rejection • Poor social circumstances • Poor nutrition • Poverty • Racial injustice • Stigma and discrimination (e.g. racism, sexism) • Social disadvantage • Social or cultural discrimination • Urbanization • Work stress	**Social continued** • Unemployment • Caring for people who are chronically ill or who have dementia • Child abuse and neglect • Elder abuse • Exposure to aggression, violence and trauma • Access to drugs and alcohol • Family conflict or family disorganization • Low social class • Parental mental illness • Parental substance abuse • Personal loss – bereavement • Stressful life events • Substance use during pregnancy • Lack of support services

Table 2 Protective Factors

PROTECTIVE FACTORS			
Psychological • Ability to cope with stress • Ability to face adversity • Adaptability • Autonomy • Early cognitive stimulation • Exercise • Feelings of security • Feelings of control • Literacy • Positive attachment and early bonding • Problem solving skills • Pro-social behaviour • Self-esteem and self-acceptance • Skills for life • Social and conflict management skills • Socio-emotional growth • Competency	**Psychological continued** • Resiliency • Self-efficacy • Agency or locus of control • Self-acceptance • Optimism and hopefulness • Stress management • Sense of coherence • Sense of belonging **Structural** • Safe and secure environments • Economic Security • Employment • Positive educational experience • Access to support services • Equity	**Social** • Empowerment • Ethnic minorities integration • Positive interpersonal interactions • Social participation • Social responsibility and tolerance • Social services • Social support networks • Safe and supportive relationships, communities and environments • Safe maternal behaviour during pregnancy • Good parenting • Positive parent-child interactions	**Social continued** • Social support of family and friends • Supportive social relationships • Mental health promoting schools and workplaces • Pro-social behaviour • Socio-emotional growth • Community participation • Social capital • Social equity

MHP addresses the protective and risk factors by taking action on the determinants of health, which include income and social status; social support networks; education and literacy; employment and working conditions; social environments; physical environments; personal health practices and coping skills;

healthy child development; health services; culture; gender; and biology and genetic endowment (Public Health Agency of Canada, [PHAC], 2001). The determinants of health exert a powerful impact on the health (and mental health) of individuals, communities and societies. For example, a review done for WHO found that high levels of unemployment and economic instability is associated with significant mental health problems and adverse effects on the physical health of not only unemployed individuals, but also their families and their communities (PHAC, 2001). Because of this, action on the determinants of health is fundamental to MHP activities (Barry & Jenkins, 2006; GermAnn & Ardiles, 2009).

In addition to the determinants of health, MHP also focuses on altering the determinants of mental health. Keleher and Armstrong (2006) identified three key determinants of mental health. The first determinant of mental health is social inclusion. This determinant represents the degree to which an individual feels connected to their community and includes social capital, social networks, social connectedness, supportive relationships, involvement in community and group activities, and civic engagement. The second determinant is related to stigma, discrimination and violence. Stigma, discrimination and violence can strongly influence mental health of individuals, communities, and society as a whole. Victims of stigma, discrimination, and violence often have their human rights violated, thereby making it difficult for them to integrate into society and lead well-balanced and productive lives. Without security and freedom from stigma, discrimination and violence, it is difficult for

individuals to maintain a high level of positive mental health (Keleher & Armstrong, 2006).

Access to economic resources is the third determinant of mental health. This determinant represents the strong correlation between economic resources and positive mental health across the lifespan. Economic resources, including employment, education, housing, and income, protect and promote mental health and wellbeing (Keleher & Armstrong, 2006). In addition to these key determinants of mental health, BC Ministry of Health Services has identified other factors that influence mental health, including resiliency, social and emotional competence, economic participation and human rights protection, as being important (BC MoH, 2007a).

PURPOSE OF PAPER

This purpose of this paper is to examine the current awareness and understanding of mental health promotion among tertiary care providers working within British Columbia's Provincial Health Services Authority. It is proposed that tertiary care providers will have an understanding of the relationship that exists between mental and physical health, as well as the individual and social level factors that affect one's mental health. Tertiary care providers will however have minimal awareness and understanding of mental health promotion, and will confound mental health promotion with mental illness prevention.

DISCUSSION OF THE PROBLEM

Mental health is a fundamental component and determinant of health and quality of life. WHO defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2007). Positive mental health is a resource for everyday life that contributes to the effective functioning of individuals, communities and societies. MHP is “the process of enhancing the capacity of individual communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience while showing respect for culture, equity, social justice, interconnections and personal dignity” (Health Canada, 1997, pg. 4-5). MHP is a key primordial and primary prevention strategy that is increasingly being recognized at the international level as a key public health strategy to address the ever growing burden of mental illness (Barry & Jenkins, 2006; Canadian Mental Health Association, [CMHA], 2008; WHO, 2004b).

There is a growing incidence, prevalence and severity of mental illness worldwide. It is estimated that by 2020, mental illness will be the second leading cause of the global burden of disease (Marshall Williams, Saxena & McQueen, 2005; Murray & Lopez, 1996; Jané-Llopis et al., 2005). Currently in British Columbia (BC), mental illness is the third largest contributor to the overall burden of disease and is the leading cause of

disability in the province (BC MoH, 2001; BC MOH, 2007b). The economic and social cost associated with the burden of mental illness is substantial. In Canada, it is estimated that the annual impact of mental illness in terms of treatment and disability alone is approximately $14.4 billion (2001) (GermAnn & Ardiles, 2009; Stephens & Joubert, 2001). The social problems related to mental illness include increased school dropout rates, absenteeism from work, reduced productivity, lost employment, reduced social capital, stigma and discrimination, increased levels of crime, and decreased perception of public safety etc. (Jané-Llopis et al., 2005; Jané-Llopis, & Hosman, 2005).

Evidence also indicates that mental illness disproportionately affects people who are socio-economically disadvantaged, while also contributing directly to the indicators of poverty, including unemployment, low education attainment, poor housing and low income (BC MoH, 2007a; Desjarlais et al., 1995; Jané-Llopis & Braddick, 2008; Moodie & Jenkins, 2005). Keleher and Armstrong (2006) showed that people disadvantaged by chronic illness, low income, unemployment and violence are more likely to experience mental health problems. Desjarlais et al. (1995) showed that the interaction between mental, social and behavioural problems is more prevalent and difficult to cope with in conditions of unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle and human rights violations. Social and material deprivation therefore weakens mental health and predisposes people to mental illness (GermAnn & Ardiles, 2009).

In addition, mental health is increasingly seen as being vitally important to physical health and quality of life and therefore needs to be addressed as an important

component of improving overall health and wellbeing. Mental and physical health are intimately connected through a variety of complex bidirectional mechanisms (Canadian Institute for Health Information, [CIHI], 2009; GermAnn & Ardiles, 2009; Herrman and Jané-Llopis, 2005; WHO, 2004b). For example, depression, anxiety, social isolation, and lack of social support are significant risk factors for cardiovascular disease, stroke, diabetes and cancer (Anderson, Freedland, Clouse & Lustman, 2001; Carson et al., 2000; Do Boer, Ryckman, Pruyn & Van den Borne et al., 1999; Goldney, Ruffin, Fisher & Wilson, 2003; Keleher & Armstrong, 2006; Kuper, Marmot & Hemingway, 2002; WHO 2004b); cardiovascular disease and cancer can increase the risk of depression (Marmot and Wilkinson, 1999; Moodie, & Jenkins, 2005); learned helplessness, hopelessness and depression are associated with decreased immunological activity and an increased risk of tumour growth and infections (Kopp, Skrabski, & Szedmák, 2000); depression, anxiety, and adjustment disorders have been associated with HIV/AIDS (Herrman & Jané-Llopis, 2005). The evidence suggest that mental and physical health are intimately related and that promoting positive mental health may significantly improve physical health outcomes (Herrman, Saxena, Moodie, & Walker, 2005; Raphael, Schmolke & Wooding, 2005). From a public health policy and practice perspective, understanding the interconnected relationship between mental and physical health is critical to a more holistic understanding of health promotion, disease prevention, and disease treatment.

It is becoming increasingly clear that treatment and rehabilitation approaches alone are not sufficient to deal with and reduce the growing burden of mental illness. For example, an Australian study found that even if everyone with a mental illness had

access to services that follow current best practices, only 40% of the overall impact of mental illness on society would be avoided (Andrews et al., 2004). To effectively combat this growing burden, it is strongly recommended that a comprehensive population health approach that places importance on the promotion of positive mental health and on the prevention of mental illness, in addition to treatment and rehabilitation, be implemented (Barry & Jenkins, 2006; GermAnn & Ardiles, 2009; Herrman & Jané-Llopis, 2005; WHO, 2004b).

Systematic reviews of MHP initiatives have demonstrated various benefits. These include long lasting positive effects on multiple levels of functioning; improved positive mental health; reduced risks of mental disorders; increased social and economic benefits, such as higher educational attainment, greater productivity at work, improved interpersonal relationships and social capital, reduction in crime rates, and decreased harms associated with substance use; reduced rates, severity of and mortality from physical illness; and reduced risk behaviours, such as tobacco, alcohol and drug misuse, and unsafe sex (BC MoH, 2007a; Durlak & Wells, 1997; Hosman & Jané-Llopis, 1999; Jané-Llopis, Hosman, Jenkins & Anderson, 2005; Jané-Llopis, et al., 2003; Moodie & Jenkins, 2005; Mrazek and Haggerty, 1994; WHO 2004a; WHO, 2004b).

Evidence suggests a need to develop mental health promoting healthcare systems and delivery of care that ensures “appropriate care and treatment is in place for those experiencing mental ill-health while at the same time developing a greater focus on promotion of mental health and prevention of mental illness” (WHO, 2004b, pg. 4). Such a system will reinforce the multi-factoral nature of health and encourage holistic

clinical engagement. The development and sustainability of a mental health promoting healthcare system however is dependent on having a skilled and informed workforce (Barry & Jenkins, 2006). Recommended activities include continued education and training among healthcare professionals to develop and build capacity and expertise to ensure evidence-based MHP is effectively integrated into practice and program delivery (Barry, 2007; Barry & Jenkins, 2006; BC MoH, 2007b; Jané-Llopis & Anderson, 2005a; Jané-Llopis & Anderson, 2005b).

CONTEXT

Over the past decade, many organizations have been responsible for advancing the MHP and mental illness prevention (MIP) agenda in BC and in Canada. The main activities that have contributed to the promotion of mental health and the prevention of mental illness at the national and provincial level are described below.

National

In February 2003, the Standing Senate Committee on Social Affairs, Science and Technology conducted Canada's first national study on mental health, mental illness and addiction. The study led to the 2006 report *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Kirby & Keon, 2006). A key recommendation of the report was to establish a Mental Health Commission of Canada. The Commission, incorporated in 2005, identified four key initiatives: reducing stigma and discrimination; developing a knowledge exchange centre; creating a mental health strategy for Canada; and homeless research demonstration projects (GermAnn & Ardiles, 2009). The national mental health strategy, the third initiative, will seek to achieve the best possible mental health and well-being for all Canadians (Mental Health Commission of Canada, [MHCC], 2009). In 2009, in preparation for the national mental health strategy, the Commission released the report *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*. The framework identified seven

goals that represent what a transformed mental health system should entail (MHCC, 2009). MHP and mental illness prevention (MIP) were identified as the second goal outlined in the framework. In addition to this goal, MHP and MIP principles were interwoven through the other six goals identified in the framework. These goals will inform subsequent phases of the national mental health strategy development process (MHCC, 2009).

In addition to the work being done by the Mental Health Commission of Canada, other organizations have been responsible for advancing the MHP and MIP agenda in Canada. In 2005, the Centre for Addiction and Mental Health and the Centre for Health Promotion at the University of Toronto co-chaired a Mental Health Promotion Summer Institute. The Summer Institute generated interest in continued discussions related to the development of MHP policy in Canada (GermAnn & Ardiles, 2009; University of Toronto Centre for Mental Health Promotion, 2009).Two years later, BC Mental Health and Addiction Services hosted a Mental Health Promotion Symposium *No Health Without Mental Health: Community Approaches to Mental Health Promotion*. Many of the Symposium participants indicated an interest in, and a desire to influence MHP policy in Canada (GermAnn & Ardiles, 2009; University of Toronto Centre for Mental Health Promotion, 2009).

Following the Symposium, discussions related to MHP and policy continued among a group of experts from across Canada. This group evolved into the Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention. A key activity of the Pan-Canadian Committee was to plan a National Mental

Health Promotion and Mental Illness Prevention Think Tank “to generate recommendations for submission to the Mental Health Commission of Canada for consideration in its national mental health framework; and to inform mental health promotion and mental illness prevention policy development and implementation at the provincial and territorial level” (GermAnn & Ardiles, 2009, pg. 14). In preparation for the Think Tank, the Pan-Canadian Committee commissioned a background paper entitled *Toward Flourishing For All: Mental Health Promotion and Mental Illness Prevention Policy Background Paper* (GermAnn & Ardiles, 2009). Five key questions for consideration in developing and implementing MHP & MDP policy were proposed in the background paper. These questions formed the basis of small focus groups at the Calgary Think Tank (GermAnn & Ardiles, 2009). The National Mental Health Promotion and Mental Illness Prevention Think Tank was held in Calgary, Alberta in November 2008. Following the Think Tank, the Pan-Canadian Steering Committee prepared the report *Toward Flourishing for All: National Mental Health Promotion and Mental Illness Prevention Policy for Canadians*, which identified the main recommendations and key messages that arose from the Think Tank. These recommendations and key messages were forwarded to the Mental Health Commission of Canada.

Provincial

The Provincial government is currently in the process of developing a 10-year plan to address mental health and addiction in British Columbia. Consultation with internal and external stakeholders identified MHP and MIP as key components to the plan. As such, it is anticipated that MHP and MIP will be identified as key priorities and

MHP and MIP principles will be embedded throughout the plan. The Plan is projected to be disseminated in fall 2010.

In 2005, the BC Ministry of Healthy Living and Sport (previously the BC Ministry of Health) released a policy framework to help strengthen public health and improve population health in British Columbia (BC) (BC Ministry of Health Services Population Health and Wellness, 2005). The *Framework for Core Functions in Public Health* identified twenty one core programs that represent what a renewed and comprehensive public health system must provide (BC Ministry of Health Services Population Health and Wellness, 2005). *Mental Health Promotion and Mental Disorder Prevention* was one of the twenty one core programs identified in the framework. Each of the six BC health authorities is responsible for completing and implementing a MHP and MDP gap analysis and improvement plan by March 2013.

In preparation for the *Mental Health Promotion and Mental Disorder Prevention Core Program*, two evidence reviews were conducted; one on MHP and the second on MDP. In 2008, a working group on MHP and MDP was formed. This group was made up of experts from the BC Ministry of Healthy Living and Sport, Provincial Health Services Authority, and the regional health authorities (BC MoH, 2007b). The working group provided guidance and direction in the development of the *Model Core Program Paper for Mental Health Promotion and Mental Disorders Prevention*. The goal of the MHP component of the model core program is to improve the mental health and psychological well-being of British Columbians throughout their lifespan/lifecourse. The model core program objectives are to enhance protective factors that contribute to

positive mental health in individuals, families, workplaces and communities; prevent and/or reduce the social, environmental and individual risk factors that influence the occurrence of mental disorders; and reduce the incidence, prevalence and recurrence of mental disorders as well as the severity and impact of the illness on individuals, families and society (BC MoH, 2007b).

The *Model Core Program Paper for Mental Health Promotion and Mental Disorders Prevention* outlines a number of best practices health authorities can engage in to enhance MHP, including developing a strategy for health authority workforce training and development to enhance the knowledge and capacity of staff to support and integrate MHP and MDP into multiple health programs (BC MoH, 2007b).

Provincial Health Services Authority

Established in 2001, the Provincial Health Services Authority (PHSA) is responsible for select specialized and province-wide healthcare services across BC. The first organization of its kind in the country, PHSA works closely with the five regional BC Health Authorities and the Ministries of Health Services and Healthy Living & Sport to meet local and provincial health care needs. PHSA governs and manages eight Agencies that plan and/or provide specialized health services on a province-wide basis, including BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre, BC Mental Health & Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, and Cardiac Services of BC.

BC Mental Health & Addiction Services

BC Mental Health and Addiction Services (BCMHAS), one of the PHSA Agencies, provides a diverse range of provincial specialized and tertiary mental health and addiction services for children, adolescents and adults across the British Columbia. BCMHAS also provides provincial leadership for system-wide improvement through its work in health promotion and illness prevention; knowledge exchange; research; and academic teaching.

BCMHAS underwent an extensive strategic planning process in 2008, which included input from key representatives from regional health authorities who identified PHSA as a leader in MHP capacity building activities. Through the strategic planning process, MHP and MIP were identified as a key strategic direction for the future. BCMHAS is uniquely positioned to work with PHSA staff and clinicians to develop an effective, comprehensive educational process to ensure that MHP becomes a fundamental part of the PHSA Agency practice.

Provincial Health Services Authority Centre for Mental Health Promotion

The PHSA Centre for Mental Health Promotion (CMHP) is co-led by BC Mental Health and Addiction Services and BC Women's Hospital and Health Centre. It consists of representatives from across PHSA Agencies and programs, including BC Mental Health and Addiction Services, BC Women's Hospital and Health Centre, BC Centre for Disease Control, PHSA Employee Wellness and Safety (now Lower Mainland Consolidated HR Services under VCH leadership), and the PHSA Aboriginal Health

Program. PHSA CMHP members have expertise across the spectrum of MHP, MIP and substance use issues and expertise and/or interest in population and public health.

In June 2009, the PHSA CMHP submitted a proposal for the *Provincial Health Services Authority Mental Health Promotion Capacity Building Project* in response to the Request for Proposal circulated by the PHSA Centres for Population and Public Health. The *Provincial Health Services Authority Mental Health Promotion Capacity Building Project* was awarded three-year funding (September 2009 – March 2012).

In March 2010, the PHSA CMHP completed PHSA's Gap Analysis and Improvement Plan for the *Mental Health Promotion and Mental Disorder Prevention Core Program*, in conjunction with the *Prevention of Harms Associated with Substances Core Programs*. The Improvement Plan outlined a number of key activities to address the gaps identified in the gap analysis, including the development and implementation of the *Provincial Health Services Authority Mental Health Promotion Capacity Building* P*roject*[1].

Provincial Health Services Authority Mental Health Promotion Capacity Building Project

The *Provincial Health Services Authority Mental Health Promotion Capacity Building Project* aims to enhance the capacity of PHSA staff and clinicians to incorporate MHP into all clinical and community assessments, and care and discharge planning. Phase I aims to examine the current state of MHP within PHSA's tertiary care services

[1] PHSA's *2009-10 Gap Analysis & Improvement Plan: Mental Health Promotion & Mental Disorder Prevention and Prevention of Harms Associated with Substances Core Programs* can be found at http://www.phsa.ca/NR/rdonlyres/B353FAAA-9142-494D-9AD3-948ED48E204A/0/FINALCMHPGAIPMarch2010.pdf

(September 2009 – March 2010). This will be accomplished by conducting group discussions and key informant interviews with frontline staff, and middle- and senior-level management from across the PHSA Agencies, including BC Mental Health and Addiction Services, BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre, and BC Women's Hospital and Health Centre. Building on the findings from Phase I, Phase II and III will aim to develop sustainable educational and training and resources to facilitate the incorporation of MHP into PHSA tertiary care services (April 2010 – March 2012).

METHODOLOGY

Qualitative research methods were employed to explore the current awareness and understanding of MHP among tertiary care providers at PHSA. Qualitative research is an exploratory approach that allows participant meanings about a concept or phenomenon to be collected and understood among a group of people in which the topic has not been previously addressed (Creswell, 2003; Morse, 1991).

Focus Groups

Focus groups were conducted with tertiary care providers from several PHSA Agencies, including BC Mental Health and Addiction Services (Child and Adolescent Mental Health & Addiction; Forensic Psychiatric Services Commission; and Riverview Hospital), BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre, and BC Women's Hospital and Health Centre. Focus groups were selected as they offer an in-depth understanding of subjective perspectives, opinions, feelings, attitudes and motivations about a topic. There are many advantages and disadvantages to focus groups. Some advantages of focus groups are that they are quick and relatively easy to organize; the group dynamics can provide beneficial information that individual data collection does not provide; they allow participants to build on each other's thoughts and opinions; and are useful in gaining insight into a topic, concept or idea that is innovative among the target population (Centre for

Disease Control, [CDC], 2008; Edmunds, 1999). Disadvantages are that focus groups are susceptible to facilitator bias, the discussion can be dominated or sidetracked by one or a few individuals, data analysis is time consuming, does not provide valid information at the individual level, and that the information collected is not representative of other groups (CDC, 2008). Key informant interviews were also conducted for participants who were unable to attend the focus groups but were interested in participating.

A total of 21 focus groups and 2 key informant interviews were conducted with 124 tertiary care providers from Wednesday, November 18th, 2009 to Tuesday, March 2nd, 2010 (Appendix A – Focus Group Breakdown). Focus groups were made up of 3-10 participants. In-person participation was encouraged however, on occasion, participants attended via teleconferencing and video-conferencing. The focus groups and key informant interviews were recorded using a digital recording device.

Mental Health Promotion Discussion Guide

A *Mental Health Promotion Discussion Guide* was developed to direct the focus groups and key informant interviews (Appendix B - Mental Health Promotion Discussion Guide). The Guide was based on an extensive literature review related to MHP and revised following the first three focus groups. The Guide consists of three sections with a total of eight questions. The first section, Awareness and Understanding of Mental Health Promotion, formed the basis of this paper. The additional two sections, including Mental Health Promotion Strategies, Barriers and Facilitators, and Preferred Learning

Methods, will inform Phase II and Phase III of the PHSA Mental Health Promotion Capacity Building Project.

Participants

Given the intricate relationship that exists between mental and physical health, evidence suggests that the promotion of mental health be built into healthcare systems and the delivery of care for physical and mental conditions (WHO, 2004b). Developing mental health promoting healthcare systems and delivery of care is essential for "enhancing psychosocial functioning of individuals and promoting support, education, resilience, relationships that are empathetic and reciprocal and mature defenses in response to stress" (WHO, 2004b, pg. 14), as they may promote positive mental health even in the face of illness, physical or mental. The development and sustainability of a mental health promoting healthcare system however is dependent on having a skilled and informed workforce (Barry & Jenkins, 2006). For this reason, it is recommended that healthcare professionals engage in continued education and training to develop and build capacity and expertise to ensure evidence-based MHP is effectively integrated into practice and program delivery (Barry, 2007; Barry & Jenkins, 2006; BC MoH, 2007b; Jané-Llopis & Anderson, 2005a; Jané-Llopis & Anderson, 2005b). In fact, the BC Ministry of Healthy Living and Sport (previously the Ministry of Health) recommended in the *Mental Health Promotion and Mental Disorder Prevention Model Core Program* paper that health authority workforce in BC participate in education and training opportunities to enhance the knowledge and capacity of staff to support and integrate MHP and MDP into the delivery of healthcare (BC MoH, 2007b).

For this reason, tertiary care providers were selected as the target group for the *PHSA Mental Health Promotion Capacity Building Project.*

Participant Recruitment

Clinical and community programs from BC Mental Health and Addiction Services (Child and Youth Mental Health; Forensic Psychiatric Services Commission; and Riverview Hospital), BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre, and BC Women's Hospital and Health Centre were identified to participate in the focus groups and key informant interviews. Key contacts from the clinical and community programs assisted with scheduling the focus groups, including confirming meeting date, time and location, and recruiting participants.

Recruitment strategies varied among PHSA Agencies. Recruitment strategies included emailing an invitation letter (Appendix C – Invitation Letter) to all staff and clinicians of identified clinical and community programs for self-identification; emailing an invitation letter to specific individuals to participate in the discussion; and recruiting entire clinical and community departments, programs, committees and groups.

All 124 participants were employed by the Provincial Health Services Authority and represented a range of healthcare professionals, including coordinators, mangers, directors, professional practice leads, department heads, educators, physicians, nurses, social workers, psychologists, occupational therapists, etc. (Appendix D – Participant Breakdown). Of the 124 participants, 35 were social workers, psychologists,

psychiatrists, counsellors or Child Life Specialists. It is important to note that only a small amount of the 124 participants worked within mental health services (n = 32).

Procedures

Prior to the arrival of the participants, the Moderator arranged the meeting room with the chairs positioned comfortably around the table. The Moderator welcomed each of the guests as they arrived. The focus groups and key informant interviews followed the same process, which included Welcome and Introductions; Project Introduction (Appendix E – Introduction Script); Administration of the Mental Health Promotion Discussion Guide; Next Steps; and Thank you and Adjournment (Appendix F – Thank you Script).

A Participant Information Form was distributed to all participants and reviewed by the Moderator prior to commencing the focus groups and key informant interviews (Appendix G – Participant Information Form). Participants were also given a Mental Health Promotion Fact Sheet (Appendix H – Mental Health Promotion Fact Sheet).

Thematic Analysis

Thematic analysis is a qualitative methodical approach to analyze and interpret recurrent themes and to identify patterned relationships within the data (Braun & Clark, 2006). Thematic analysis rests on the assumption that individual's have their own personal ideas, opinions and understandings, which represent their experience (Wilkinson, 2003). Some would claim that thematic analysis is not a specific methodological approach to qualitative research, but rather a tool used across different

methods (Boyatzis, 1998; Braun & Clark, 2006; Ryan & Bernard, 2000). However, it is argued that by applying clear and concise guidelines and rules, as well as explicitly identifying epistemological assumptions, thematic analysis is in fact a methodological approach to qualitative research (Braun & Clarke, 2006). Moreover, thematic analysis is a useful approach for producing qualitative analyses suited to inform policy development (Braun & Clark, 2006).

Codes and Themes

The focus groups and key informant interviews were rigorously transcribed using an orthographic notation. The transcripts were checked against the recordings for accuracy. Transcripts were reviewed and codes were generated (Appendix I – Codes).

Using the computer software program NVivo 8 (QSR International, 2007), transcripts underwent a thorough, inclusive and comprehensive coding process, with each data item given equal attention. The sentences from which the data extracts stem were also included so that the data extracts could be analyzed within the context of the statement. Transcripts and codes were reviewed multiple times. Recurrent themes were then generated from the data themselves (Appendix J – Themes). Definitions were assigned to each of the identified themes. All coded data extracts were then grouped under the appropriate thematic headings. The themes and related data extracts were then checked against each other and back to the original data set.

Data Analysis

For the data analysis process, data extracts, codes and themes were analyzed for each of the three questions outlined in the *Mental Health Promotion Discussion Guide*. Main themes and codes were identified based on frequency. While frequency is not necessarily a measure of significance, it offers a sense of the extent to which a particular construct was common across responses, and hence the extent to which it might be understood and more broadly shared (Braun & Clark, 2006). The main themes and related codes were then analyzed to investigate patterns and commonality.

RESULTS

Awareness and Understanding of Mental Health Promotion

Relationship between Mental and Physical Health

Four common themes arose from the discussions regarding participants' understanding of the relationship between mental and physical health (Table 3). The main theme that arose was related to the connection between mental and physical health (66%). All of the groups described the relationship between mental and physical health as being interconnected, related, circular, and intertwined. During this discussion, some participants expressed concern with positioning health as a state of complete mental and physical health, as it may result in individuals blaming themselves for their physical ill health.

Five of the groups discussed the differing levels of awareness and understanding of mental health and the relationship between mental and physical health that exists in our society, and among healthcare providers, patients and families (18%). It was acknowledged by four of the groups that the only reason this questions was posed was because Western culture views mental and physical health separately and that there are many cultures around the world that do not distinguish between the components of health, but rather view health within a holistic paradigm. Participants also discussed the importance of acknowledging patients' understanding of the relationship between mental and physical health when delivering patient-centred healthcare.

The third main theme discussed among three of the groups was in regard to the healthcare system (9%). It was stated by some participants that the structure of the healthcare system is segmented and, as a result, addresses mental and physical health separately. Participants also claimed that mental health is not addressed in non-mental healthcare services.

The holistic nature of health, which includes physical, mental, emotional and spiritual health, and the concentration of overall wellbeing were discussed in eleven of the focus groups (6%). While more groups discussed this theme, it was not discussed in as much detail as themes two and three.

Table 3 Relationship Between Mental and Physical Health

What is your understanding of the relationship between mental and physical health?	
1. Connected (67%) ▪ Inter-Connected (43.1%) ▪ Related (35.5%) ▪ Personal Blame (11.0%) ▪ Intertwined (4.6%) ▪ Circular (4.6%)	**3. System (9%)** ▪ Not Addressed in System (45.4%) ▪ Segmented System (37.9%) ▪ Duality (16.7%)
2. Awareness and Understanding (18%) ▪ Society and Culture (47.7%) ▪ Patients' Understanding of the Relationship (33.8%) ▪ Definition of Mental Health (18.4%)	**4. Holistic (6%)** ▪ Holistic (77.8%) ▪ Overall Wellbeing (22.2%)

Determinants of Mental Health

Participants identified over eighty determinants of mental health. The mental health determinants were categorized into eleven themes: social; psychological; systematic; cultural; socioeconomic; physiological; biological; physical; determinants of

health; substance use; and developmental determinants (Table 4). All of the twenty-three groups discussed the importance of the social determinants on mental health (33%), including social support networks, trauma, social context of an individual's life, external expectations, relationships, stigma and discrimination, etc.

The second theme, psychological determinants (27%), was discussed by twenty-two of the groups. Psychological determinants are defined as factors that influence, or intend to influence, mind or emotions. These include the psychological effects of trauma, expectations, stigma and discrimination, stressors, a sense of contribution, purpose, belonging, and acceptance, sense of self, locus of control, coping, resiliency, etc.

Systematic determinants (13%), discussed by twenty-one groups, included access to health and community resources and services, the extent to which the broader societal system contributes to poverty, and the stigma and discrimination that exists among healthcare providers, the healthcare system, and the broader societal system.

The fourth key theme is related to the role culture plays on one's mental health (11%). This theme includes the cultural context of trauma, stigma and discrimination, cultural identity and ethnicity. For example, some participants discussed the traumatic experiences of Aboriginal peoples related to colonization and residential schools. It was also discussed that some cultures do not accept mental ill health and therefore, individuals with mental health problems are often stigmatized.

Table 4 Determinants of Mental Health

What factors would you consider determines one's mental health?	
1. Social (33%) ▪ Social Support Networks (8.5%) ▪ Trauma (8.2%) ▪ Social Context (7.9%) ▪ Expectations (7.6%) ▪ Relationships (7.2%)	**7. Biology (1%)** ▪ Genetics and Biology (72.1%) ▪ History of Mental Illness (26.7%) ▪ Age (1.2%)
2. Psychological (27%) ▪ Trauma (9.9%) ▪ Expectations (9.2%) ▪ Stigma and Discrimination (7.3%) ▪ Sense of Contribution, Purpose, Belonging and Acceptance (5.4%) ▪ Perception (4.9%)	**8. Physical (1%)** ▪ Geography (56%) ▪ Environment (44%)
3. System Related (13%) ▪ Access to Services (35.5%) ▪ Poverty (11.6%) ▪ Stigmatizing System (7.3%) ▪ Culture and Ethnicity (7.1%) ▪ Stereotypes (6.0%)	**9. Determinants of Health (0.6%)** ▪ Whole Being (37.9%) ▪ Determinants of Health (33.3%) ▪ Internal/External Factors (18.2%) ▪ All Factors (6.0%) ▪ Quality of Life (4.6%)
4. Culture (11%) ▪ Trauma (25.4%) ▪ Stigma and Discrimination (18.7%) ▪ Culture and Ethnicity (15.1%) ▪ Stereotypes (7.3%) ▪ Racism (6.4%)	**10. Substance Use (0.2%)** ▪ Substance Use (100%)
5. Socioeconomic (9%) ▪ Socioeconomic Stressors (22.17%) ▪ Financial Resources/Status (20.8%) ▪ Stress (20.4%) ▪ Poverty (17.1%) ▪ School/Employment (8.9%)	**11. Developmental (0.2%)** ▪ Developmental (86.4%) ▪ Learning Disability (13.6%)
6. Physical Health (4%) ▪ Physical Health Condition (45.8%) ▪ Medical (29%) ▪ Medications (14.5%) ▪ Lifestyle Behaviours (10.7%)	

Socioeconomic determinants (9%) were acknowledged by twenty-two of the groups, but were discussed in less detail then the aforementioned themes. Specific

socioeconomic determinants included poverty indicators, such as financial resources and status, employment status, and educational status and attainment. While the determinants of health were discussed by all of the groups, the term 'determinants of health' and the holistic approach to health were only discussed by eight of the groups.

Additional themes included physiological (e.g., physical health status, medication) (4%), biological (e.g., genetics, biology, history of mental illness) (1%), physical (geography, environment) (1%), determinants of health (whole being, determinants of health) (0.6%), substance use (0.2%), and developments (e.g., developmental, learning disabilities) (0.2%) determinants.

Mental Health Promotion

When asked to define MHP (Table 5), nineteen groups focused primarily on health education and health promoting activities (30%). The discussion primarily focused on taking time to ask questions and to be supportive, calm and caring with patients and families. It also included health education (e.g., educating patients, families and the general public on mental health, nutrition, and physical activity) and health promoting activities (e.g., exercise, yoga, and meditation programs, stress management, and support groups).

Participants also discussed MHP as taking action on protective factors related to mental health (27%). This included building individual capacity and skills (e.g., capacity and skills related to resiliency and self-esteem), coping strategies, and relationship building. This theme was discussed by twenty of the groups.

Table 5 Defining Mental Health Promotion

How would you define mental health promotion?	
1. Health Promotion and Education (30%) ▪ Asking Questions, Being Supportive, Calm and Caring (49.4%) ▪ Education (18.6%) ▪ Health Promoting Activities (10.2%) ▪ Normalizing Experience (9.4%) ▪ Promoting Quality of Life (5.8%)	**5. Risk (8%)** ▪ Self-Care and Self-Management (46.3%) ▪ Mental Illness Prevention (32.9%) ▪ Stress, Anxiety and Anger Management (17.8%) ▪ Screening (2.5%) ▪ Symptom Management (0.5%)
2. Protective (27%) ▪ Building Individual Capacity and Skills (18.9%) ▪ Coping Strategies (13.1%) ▪ Building Relationships (12.1%) ▪ Empowerment (8.3%) ▪ Creating Cultural Safety (6.9%)	**6. System Level (7%)** ▪ Mental Health Services (38.1%) ▪ Creating Cultural Safety (32.8%) ▪ Accessing Services and Resources (15.4%) ▪ Intersectoral (10.5%) ▪ Primary Healthcare (2.7%)
3. Awareness and Understanding of Mental Health and Mental Health Promotion (13%) ▪ Education (48.9%) ▪ Awareness, Understanding and Acceptance of Mental Health and Mental Health Promotion (36.6%) ▪ Differing Levels of Mental Health Promotion (10.8%) ▪ Awareness of Relationship between Mental and Physical Health (3.7%)	**7. Patient Centred (4%)** ▪ Empowerment (57.9%) ▪ Individual Strategies (42.1)%
4. Holistic (11%) ▪ Focus on Wellbeing (26.7%) ▪ Addressing Determinants of Health (19.6%) ▪ Focus on Positive Aspects of Health (14.8%) ▪ Promoting Quality of Life (12.9%) ▪ Moving towards Health Approach (10.9%)	

The third theme discussed by eleven of the groups was in relation to increasing awareness and understanding of mental health and MHP through variety of activities,

such as education (13%). It was also acknowledged by some participants that MHP can be applied at the individuals, community or population level.

The holistic nature of MHP was discussed by eleven of the groups (11%). More specifically, participants acknowledged that MHP focuses on wellbeing, the determinants of health, and positive aspects of health. A focus on risk factors was also identified by fifteen of the groups (8%). This theme concentrated on self-care/management, MIP, and stress/anxiety/anger management. Additional themes discussed by eight and six of the groups included system level (7%) and patient centred (4%) approaches, respectively.

DISCUSSION

Awareness and Understanding of Mental Health Promotion

The complex bidirectional relationship that exists between mental and physical health was well understood by all participants. While the interconnected nature of the relationship was thoroughly acknowledged, the discussion about the relationship was positioned within a traditional biomedical paradigm (i.e., one that focuses on treating physical illness). Participants rarely positioned the relationship within a holistic paradigm that views the patient as a whole person and addresses the physical, mental, emotional, social and spiritual needs of the patient, in addition to their physical treatment. The principle of holistic healing is to balance the body, mind, spirit, and emotions to optimize health and overall wellbeing (WHO, 2004b). According to WHO "to promote mental health globally and in terms of physical and mental illnesses, such a holistic view is critical" (WHO, 2004b, pg. 144).

It was acknowledged by some participants that the only reason they were being asked about the relationship between mental and physical health was because we live in a Western society and culture that views mental and physical health separately. Holistic concepts of health are basic to many cultures around the world, particularly indigenous populations. For example, in Australia, the National Aboriginal Health Strategy Working Party defined health as "… not just the physical health well-being of the individual but the social, emotional, and cultural well-being of the whole

community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life" (Swan & Raphael, 1995, p. 1). Additionally, participants discussed how the separation of mental and physical health not only occurs within the Western society and culture but also within the healthcare system. For example, one participant stated that "the very framework of the question highlights where we're at in contemporary medicine, which is to separate them both" (personal communication, Focus group Participant, January 19, 2010). "The separation of medical and mental health care is a worldwide practice leading to unacceptable clinical and economic outcomes in virtually all countries and cultures" (Kathol & Clarke, 2005, pg. 817). Based on the increasing evidence that demonstrates the complex interrelationships between mental and physical health, healthcare services should no longer address mental and physical health and illness independently of one another. Mental health should be integrated into all medical services (Kathol and Clarke, 2005; WHO, 2004b).

Some participants criticized positioning physical health as being intricately connected to mental health, as it may result in patients blaming themselves for their physical ill health. For example, one participant stated "sometimes people come in and tell me that their cancer is their fault. That somehow that's been a weakness of theirs. That somehow they caused it" (personal communication, Focus group Participant, January 18, 2010). Positioning health in this manner however, does not seek to foster a "blame the victim" attitude, but rather seeks to encourage individuals to take a holistic approach to their health and to become empowered to regain control over their health and quality of life (Baer et al., 1998; Bell 1996).

Mental health is not only determined by the physical and psychological make up of an individual, but also by their interpersonal and social surroundings, and the external social, economic and political environmental forces (Barry & Jenkins, 2006; BC MoH, 2007a; Desjarlais et al., 1995; Herrman, & Jané-Llopis, 2005; Hosman and Jané-Llopis, 1999; Marmot and Wilkinson, 1999; Mrazek and Haggerty, 1994; WHO, 2004a). The factors that determine mental health can be clustered into three categories: individual, social and structural level factors (Barry & Jenkins, 2006). Participants showed a thorough understanding of the multiple factors that affect one's mental health, identifying over eighty determinants of mental health. Participants largely focused on the individual and social level factors, concentrating the discussion on the social/interpersonal and psychological factors affecting mental health, including social support networks, social inclusion (e.g., social connectedness and sense of community), sense of self, sense of belonging, coping skills, and the social and psychological effects of stigma, discrimination and violence. Less emphasis was placed on the broader societal and economic factors (i.e. structural level factors) that influence one's mental health, including employment, education, housing and living conditions, income and social status.

Additionally, participants infrequently used the terms 'determinants of health' and 'determinants of mental health'. When these terms were used, it did not elicit a discussion among participants around the determinants of health and their relationship with health and wellbeing. This may reflect the lack of awareness among tertiary care providers about the terminology used in public health around the determinants of

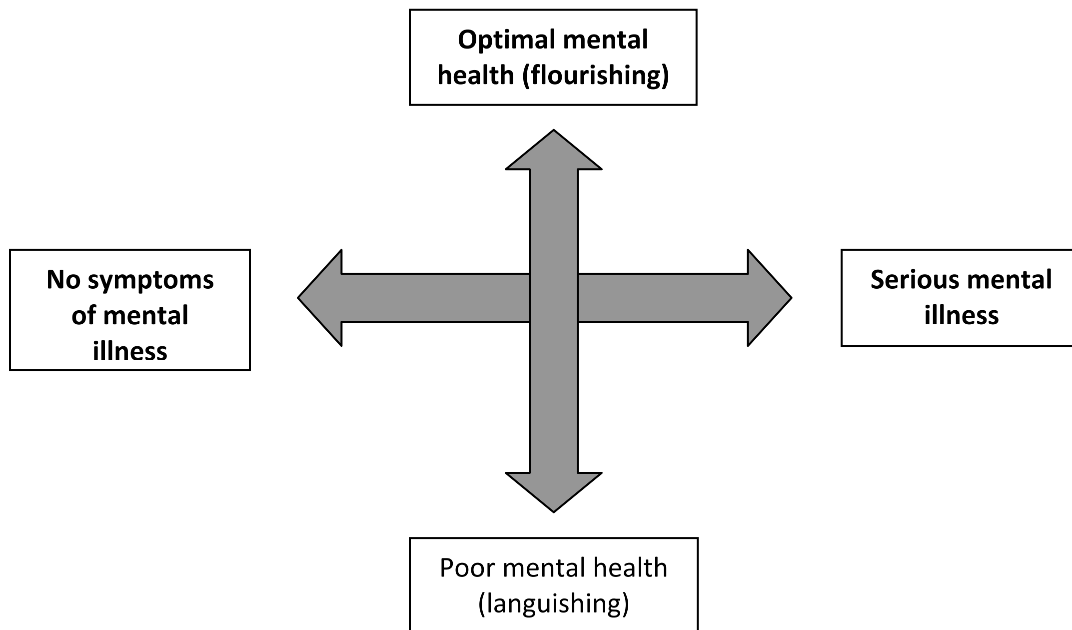
health, or may reflect minimal understanding among participants of the intricate relationship that exists between mental health and the social, economic, and political macro-level systems (Barry & Jenkins, 2006; WHO, 2004b).

When asked to define MHP, all of the groups had difficulty defining and identifying the goals, objectives and outcomes of MHP, which seeks to create safe, healthy and supportive social, economic and political environments for individuals, communities and societies by taking action on all of the determinants of health (Barry & Jenkins, 2006; Herrman, & Jané-Llopis, 2005; Hosman and Jané-Llopis, 1999; WHO, 2004b). Participants mostly defined MHP within a traditional health promotion framework that focuses on health education and health promoting activities, such as nutrition and exercise programs. Modern health promotion however, extends beyond health education and health promoting activities and includes building health public policy, creating supportive environments, strengthening community capacity and reorienting health services (WHO, 1986). Participants did however define MHP as strengthening individual protective factors, such as psychological wellbeing, competence and resilience, which is one of the objectives of MHP. Individual mental health promoting activities identified included asking questions, being supportive, calm and caring, building individual capacity and skills, coping strategies, and building relationships. These individual level mental health promoting activities however, were not connected back to the overall goal of MHP, which is to promote positive mental health and enhance wellbeing and quality of life (Barry & Jenkins, 2006; WHO, 2004b).

Participants also had difficulty distinguishing between MHP and MIP. The two continua model (Figure 1) depicts the distinct but interrelated nature of MHP and MIP (CMHA, 2006). As previously discussed, the difference between MHP and MIP lies in their targeted outcomes (BC MoH, 2007b). MIP seeks to reduce the symptoms, and ultimately the incidence and prevalence of mental illnesses, while MHP seeks to promote a positive state of mental health by increasing and strengthening psychological wellbeing, competence and resilience; strengthening protective factors for enhancing wellbeing and quality of life; and creating stronger, healthier and supportive conditions and environments (BC MoH, 2007b; Saxena, Jané-Llopis & Hosman, 2006). MHP focuses on the population as a whole rather than on people at risk for mental illnesses (Barry & Jenkins, 2006; BC MoH, 2007b; European Commission, 2008; GermAnn & Ardiles, 2009; Jané-Llopis, et al., 2005).

The two continua model is represented by two separate but intersecting continua, one for mental illness and one for mental health. The mental illness continuum (horizontal continuum) moves from the absence of mental illness/disorder to the presence of serious mental illness/disorder. MIP lies across the horizontal continuum. In the mental health continuum (vertical continuum), the bottom end represents poor mental health or 'languishing', while the upper end represents optimal mental health or 'flourishing' (CMHA, 2006; GermAnn & Ardiles, 2009; Keyes, 2002). MHP lies across the vertical continuum.

Figure 1 Two Continua Model



This model shows that people can have poor mental health, without experiencing a mental illness. Similarly, people can have a mental illness and still have good mental health and a sense of wellbeing (CMHA, 2006; GermAnn & Ardiles, 2009; Keyes, 2002). Participants were more focused on mental illness (i.e. horizontal continuum) and poor mental health/languishing (i.e. the bottom end of the vertical continuum), with minimal discussion on MHP as promoting positive/optimal mental health and flourishing.

STRENGTHS AND LIMITATIONS

There are various strengths and limitations of this research project. The *Mental Health Promotion Discussion Guide* used to facilitate the focus group discussions was not pilot tested with a subset of the target population (i.e. tertiary care providers) prior to commencing the focus groups, but rather was revised following the first three focus groups. The section on *Awareness and Understanding of Mental Health Promotion* however was not altered. It is important to note, however, that the *Guide* was based on an extensive literature review related to MHP, and was developed in consultation with the *PHSA Mental Health Promotion Capacity Building Project Steering Committee*, which includes experts in Learning and Development, as well as in MHP.

Multiple recruitment strategies were used to recruit participants for the focus groups and key informant interviews, including self-identification by participants, identifying specific individuals to participate, and recruiting entire programs and departments. Self-identification was the most common mode of recruitment, with many of the participants volunteering to participate in the focus groups and key informant interviews. These participants may have had a well-established knowledge base of MHP, which may have resulted in the findings being slightly skewed. Using multiple methods of recruitment however did lead to a large sample of participants (i.e. 124 participants). These participants represented multiple health disciplines (e.g., physicians, nurses, occupational therapists, dietitians, social workers, etc.), as well as multiple levels of

management (Project Managers, Professional Practice Leaders, Department Heads) working within PHSA. The findings discussed above therefore can be generalized to the tertiary care providers at the BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre, BC Mental Health & Addiction Services, and BC Women's Hospital and Health Centre. These findings, however, cannot be generalized to a particular health discipline, nor can they be applied to healthcare providers working outside of this tertiary care environment.

During the data analysis phase, thematic analysis was used to analyze and interpret, and to identify themes within the data. The focus groups and key informant interviews were rigorously transcribed and were checked against the recordings for accuracy. The transcripts then underwent multiple comprehensive coding processes, with each data item given equal attention. Themes were then generated from the data themselves. The themes and related data extracts were then checked against each other and back to the original data set. A second researcher then reviewed the coded data and themes to ensure validity and reliability of coding. However, due to the time constraints of the *PHSA Mental Health Promotion Capacity Building Project*, the second researcher only reviewed a small proportion of the larger dataset.

RECOMMENDATIONS

Based on the above analysis, it is recommended that academic institutions integrate health promotion and mental health promotion into the curriculum and training of all healthcare professionals. It is also recommended that health-related academic programs transition away from the traditional biomedical approach to care and begin moving towards a holistic approach that focuses on health instead of illness and treats the individual as a whole person, rather than as separate parts.

For tertiary care organizations, such as PHSA, it is recommended that MHP education and training resources be developed for tertiary care providers to gain the knowledge, skills and confidence to effectively incorporate MHP into clinical and community assessments, and care and discharge planning. The MHP education and training resources should concentrate on increasing mental health literacy among tertiary care providers. The Canadian Alliance on Mental Illness and Mental Health defines mental health literacy as the knowledge and skills that enable people to access, understand and apply information for mental health. Enhancing mental health literacy is a key strategy to improving the mental health of individuals and communities (Canadian Alliance on Mental Illness and Mental Health, 2008). The MHP education and training resources should seek to increase understanding of the holistic nature of health and of the relationship between mental and physical health; the broader societal and economic determinants of health and mental health; and of mental health promotion (e.g.,

positive mental health; flourishing). Finally, it is recommended that the MHP educational and training resources be positioned within orientation processes of all new staff and in continued education curriculum and training opportunities to support an ongoing cultural shift within the organization.

APPENDICES

Appendix A Focus Group Breakdown

PHSA Agency	# of Group Discussions	# of Participants	Healthcare Provider
BC Mental Health and Addiction Services	6 group discussions	32	▪ Case Managers (4) ▪ Clinic Manager ▪ Clinical Director ▪ Clinical Nurse Coordinators (2) ▪ Clinical Nurse Specialist ▪ Clinical Service Managers (4) ▪ Director (2) ▪ Librarian ▪ Nursing Student ▪ Nurse Supervisor ▪ Occupational Therapist ▪ Physicians (2) ▪ Professional Practice Leaders (5) ▪ Program Assistant ▪ Psychiatrist ▪ Psychologists (2) ▪ Social Worker ▪ Team Leader
BC Cancer Agency	4 group discussions	19	▪ Chief Radiation Therapist ▪ Clinical Counsellor ▪ Clinical Educator ▪ Dietitian ▪ Director ▪ Education Resource Nurse ▪ Palliative Care Physician ▪ Professional Practice Leaders (2) ▪ Psychiatrists (2) ▪ Radiation Oncologists (2) ▪ Radiation Therapist Educator ▪ Registered Nurses (2)

PHSA Agency	# of Group Discussions	# of Participants	Healthcare Provider
			▪ Social Workers (3)
BC Centre for Disease Control	1 group discussion	9	▪ Clinical Nurse Leader ▪ Education Leaders (3) ▪ Nurse Consultant ▪ Outreach Nurse ▪ Outreach Program Leaders (2) ▪ Program Manager
BC Children's Hospital and Sunny Hill Health Centre	5 group discussions 1 key informant interview	34	▪ Child Life Specialist (8) ▪ Clinical Nurse Coordinator ▪ Dietitian ▪ Directors (2) ▪ Licensed Practical Nurse ▪ Nurse Clinicians (2) ▪ Nurse Practitioner ▪ Occupational Therapists (2) ▪ Pediatrician ▪ Physical Therapist ▪ Physician ▪ Program Managers (3) ▪ Psychologists (2) ▪ Recreation Therapist ▪ Registered Nurses (2) ▪ Secretary ▪ Service Coordinator ▪ Social Worker (3)
BC Women's Hospital and Health Centre	4 group discussions	25	▪ Aboriginal Patient Liaisons (2) ▪ Clinical Educator ▪ Coordinators (3) ▪ Counsellors (4) ▪ Nurse Clinicians (4) ▪ Nurse Practitioners (2) ▪ Practice Leader ▪ Program Coordinators (2) ▪ Program Managers (2) ▪ Registered Nurses (3) ▪ Social Worker

PHSA Agency	# of Group Discussions	# of Participants	Healthcare Provider
BC Children's and Women's Hospital	1 group discussion 1 key informant interview	5	▪ Director (1) ▪ Professional Practice Leaders (4)

Appendix B Mental Health Promotion Focus Group Guide

A. Introductions

B. Awareness and Knowledge of Mental Health Promotion

1. What is your understanding of the relationship between physical and mental health?
2. What factors would you consider determines ones mental health?
3. How would you define mental health promotion (i.e. the promotion of mental wellbeing)?

C. Mental Health Promotion Strategies and Activities

1. What, if any, mental health promotion strategies and activities (i.e. tools/resources) do you, or others in your program/service area, currently use in your daily clinical and community practice?
2. In your opinion, what factors are in place that will prevent and/or assist you or other healthcare providers to incorporate mental health promotion strategies into your clinical and community practice?

D. Preferred Learning Methods

1. What types of learning methods do you prefer when learning new educational material, clinical assessment and care strategies, etc.?

E. Adjournment

- **THANK YOU** all for participating in today's focus group
- We are also looking for Champions to support the ongoing commitment of MHP and to participate on the working groups during the development, implementation and evaluation of the MHP Capacity Building tools and resources. If you are interested, or know of a Champion within your program or service area, please contact Alana Rauscher at arauscher@phsa.ca.
- If you have any questions related to the **PHSA Mental Health Promotion Capacity Building** project, please contact Alana Rauscher at arauscher@phsa.ca.

Appendix C Invitation Letter

Dear Participant,

We invite you to participate in a focus group for the **PHSA Mental Health Promotion Capacity Building** project. The goal of this project is to enhance capacity of PHSA staff and clinicians to incorporate mental health promotion into daily clinical and community assessments, and care and discharge planning. This project was funded through the PHSA Centres for Population and Public Health Primordial and Primary Prevention funding process.

The **purpose** of the focus groups is to:

- Assess current awareness and knowledge about mental health promotion;
- Assess facilitators and barriers in place that help or hinder the incorporation of mental health promotion;
- Identify existing mental health promotion tools and resources currently being used across PHSA; and
- Identify preferred delivery options for additional clinical training and education tools and resources on mental health promotion

The focus group will be **1-hour** in length. They will be comprised of 4-8 people from frontline clinical and community staff to senior level administrators. Coffee, tea and light refreshments (i.e. cookies, muffins, etc.) will be provided.

Alana Rauscher will be in contact with you regarding the date, time and location of the Focus groups.

For any questions related to the **PHSA Mental Health Promotion Capacity Building** project, please contact Alana Rauscher at arauscher@phsa.ca.

Thank you,

***Alana Rauscher**, Project Manager*
BC Mental Health & Addiction Services
Provincial Health Services Authority
Tel: 604-707-6396
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Appendix D Participant Breakdown

Department Heads, Directors, and Professional Practice Leaders	**Physicians & Psychiatrists**
Professional Practice Leader (8) Director (3) Director of Professional Practice (2) Provincial Professional Practice Leader (2) Division Head Acting Head of Psychology Director of Clinical Operations Director of Nursing Clinical Director Chief Radiation Therapist **Educators** Nurse Educator (2) Education Leader Radiation Therapist Educator Education Resource Nurse Clinical Educator **Leaders, Managers, and Coordinators** Program Manager (5) Clinical Service Manager (4) Coordinator (4) Clinical Nurse Coordinator (3) Program Coordinator (2) Outreach Program Leader (2) Senior Practice Leader (2) Case Manager Service Coordinator Clinic Coordinator Clinical Nursing Leader Team Leader Nurse Supervisor Occupational Therapist Supervisor	Psychiatrist (3) Physician (2) Radiation Oncologist (2) Palliative Care Physician Family Physician Pediatrician **Nurses** Nurse Clinician (6) Registered Nurse (4) Nurse Practitioner (3) Nurse Consultant Clinical Nurse Specialist Outreach Nurse Licensed Practical Nurse **Allied Health Care Professionals** Social Worker (9) Psychologist (4) Counsellor (4) Occupational Therapist (2) Dietitian (2) Social Work Clinician Clinical Counsellor Recreation Therapist Physical Therapy **Other** Child Life Specialist (6) Aboriginal Patient Liaison (2) Child Life Fellow Intern Librarian Assistant Secretary

Appendix E Introduction Script

I would like to start by thanking each one of you for attending the focus group for the *PHSA Mental Health Promotion Capacity Building Project*. To begin, let's go around the table and do introductions. Please provide your name, health discipline, and program or service area.

I will now provide a brief description of the project and how it came to fruition.

In 2009, PHSA launched the Provincial Health Services Authority Centres for Population & Public Health (PHSA CPPH) as part of the commitment made by PHSA's Executive Leaders Council and Board to advance population and public health within PHSA and in BC. The PHSA CPPH consist of nine Centres focused on key population and public health areas, including Mental Health Promotion, Communicable Disease Prevention, Environmental Health, Chronic Disease Prevention, Injury & Violence Prevention, Health Emergency Management, Children & Youth, Women's Health, and Aboriginal Health.

In June 2009, the PHSA CPPH circulated a Request for Proposals for primordial and primary prevention projects. This process was internal to PHSA. Each Centre prioritized and submitted selected project proposals to the PHSA CPPH Steering Committee. Submitted proposal were rated against previously set criteria by the PHSA CPPH Steering Committee. Final approval was made by the PHSA Executive Leader's Council.

The Centre for Mental Health Promotion submitted a proposal for the *PHSA Mental Health Promotion Capacity Building Project.* The Centre for Mental Health Promotion was awarded three-year funding for the *PHSA Mental Health Promotion Capacity Building Project*. The goal of the project is to enhance the capacity of PHSA staff and clinicians to incorporate MHP into all clinical and community assessments, and care and discharge planning. The project is broken down into three phases.

For Phase I, focus groups and key informant interviews will be conducted with PHSA staff and clinicians. The purpose of the focus groups and key informant interviews is to examine the current awareness and knowledge of MHP among PHSA staff and clinicians; identify current MHP strategies and activities; and identify barriers and facilitators that impede or enhance the incorporation of MHP into daily clinical and community assessments, and care and discharge planning within PHSA's clinical and community services. Focus groups and key informant interviews will be conducted with BC Mental Health and Addiction Services, BC Cancer Agency, BC Centre fro Disease Control, BC Children's Hospital and Sunny Hill Health Centre, and BC Women's Hospital and Health Centre.

The results of Phase I will inform Phase II and III, which will seek to develop and pilot sustainable mental health promotion tools and resources to enhance the capacity of

PHSA staff and clinicians to incorporate mental health promotion into daily community and clinical assessments, and care and discharge planning. Participants from Phase I will be invited to participate in the subsequent phases.

In front of you are three documents. The first document is the *Participant Information Form*, which outlines to project goals and objectives, as well as the purpose of the focus groups and key informant interviews. Review *Participant Information Form*. The second document, the *Mental Health Promotion Discussion Guide*, will guide our discussion today. The final document is a *Mental Health Promotion Fact Sheet*. The Fact Sheet defines key concepts and principles related to mental health and mental health promotion.

Let's begin!

Appendix F Thank You Script

Thank you all for attending the focus group for the *PHSA Mental Health Promotion Capacity Building Project*. Your input is most valuable and will be very helpful in informing subsequent phases of the project. Please let me know if you have any questions or comments, or are interested in participating in subsequent phases.

Appendix G Participant Information Form

The ***PHSA Mental Health Promotion Capacity Building Project*** is a PHSA Centres for Population and Public Health Primordial and Primary Prevention funded project. **Project Goal:** To enhance the capacity of PHSA staff and clinicians to incorporate mental health promotion into clinical and community assessments, and care and discharge planning. **Phase 1 Objective:** To examine the current state of mental health promotion (September 2009 – March 2010) **Phase 2 and 3 Objective:** To develop clinical and community education and training resources to facilitate the incorporation of mental health promotion into tertiary care services (April 2010 – March 2012)

You are invited to participate in a brief discussion for Phase 1 of the ***PHSA Mental Health Promotion Capacity Building Project***. The purpose of this discussion is to:

- Assess current awareness and knowledge about mental health promotion;
- Assess facilitators and barriers in place that help or hinder the incorporation of mental health promotion in clinical and community assessments, and care and discharge planning;
- Identify existing mental health promotion tools and resources currently being used across PHSA;
- Identify preferred delivery options for additional training and education tools and resources on mental health promotion.

Your participation in this discussion is completely voluntary and will imply your consent. You may answer all, some, or none of the questions that arise during this discussion. You can refuse to participate or withdraw at any time without any consequences. To ensure confidentiality, all information obtained will be held in strict confidence. No names or identifying information will be used in any publications or presentations unless consent is first obtained.

For further questions regarding the Mental Health Promotion Capacity Building project, please contact Alana Rauscher at arauscher@phsa.ca or 604-707-6396.

Thank you for participating!

Appendix H Mental Health Promotion Fact Sheet

Health
The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2009, paragraph 1).

Mental Health
For the purposes of this project, mental health is defined as "a state of well-being in which the individual realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his/her community" (WHO, 2001, pg. 1). Mental health is an integral part of overall health and well-being of individuals, families and societies.

Determinants of Health
Health is determined by multiple factors known as the *Determinants of Health*. These include:

- Income and social status
- Social support networks
- Education and literacy
- Employment and working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Health services
- Culture
- Gender
- Biology and genetic endowment

Determinants of Mental Health
Research has revealed three key socio-economic determinants of mental health that extend beyond the control of the individual. These are known as the *Determinants of Mental Health* and include:

- Social inclusion (i.e. social networks, supportive relationships, involvement in community activities)
- Freedom from discrimination and stigma
- Access to economic resources (i.e. employment, education, housing, and income)

Health Promotion
"Health promotion is the process of enabling people to increase control over, and to improve, their health" (WHO, 1986, pg. 1). The Ottawa Charter for Health Promotion (WHO, 1986) identified five key health promotion strategies, including:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

Mental Health Promotion
Mental health promotion (MHP) aims to promote positive mental health by strengthening resiliency, increasing psychological well-being, competency, coping and problem solving skills, enhancing one's ability to manage stress, increasing social connectedness and by fostering supportive environments. It is the process of enabling individuals and communities to take control over their own lives and to achieve positive mental health and quality of life.

Health Promotion and Mental Health Promotion
MHP contributes to health promotion by taking action on individual, social, cultural, economic, political and environmental levels to create positive mental health promoting environments.

Mental health promotion and health promotion both:
- Focus on the enhancement of well-being rather than on illness
- Address the population in the context of everyday life
- Are oriented toward taking action on the *Determinants of Health*
- Include multi-level interventions across a wide range of sectors, policies, programs, settings and environments

Mental Illness Prevention
Mental illness prevention (MIP) aims to enhance protective factors and minimize risk factors in order to:
- Reduce the risk, incidence and prevalence of mental illness
- Prevent or delay the recurrences of mental illness
- Decrease the impact of mental illness in the affected persons, their families, and society

Population Lenses
The population lens (i.e. gender lens, diversity lens, inequities lens) takes action on individual, social, cultural, economic, political and environmental and factors to reduce inequalities in health within and between population groups.

Vulnerable or at-risk population groups include:

- Immigrant and diverse cultural groups
- Aboriginal people
- People of low socioeconomic status
- Residents of remote, rural and northern communities

Protective Factors and Risk Factors

Protective factors are those factors that moderate and mitigate the effects of risk factors in order to reduce the risk and severity of mental illness and to increase the likelihood of positive mental health. They include: ability to cope with stress, adaptability, literacy, self-esteem, resiliency, locus of control, social support networks, strong and positive family bonds, and economic security.

Risk factors are those factors that increase the likelihood that an individual will develop mental health problems. Risk factors can also worsen existing mental health problems. Thy include: chronic pain, displacement, chaotic home environments, parental substance abuse or mental illness, lack of parent-child attachments and nurturing, abuse social isolation or alienation, peer rejection, poverty and employment.

The absence of protective factors in the presence of risk factors can result in behaviours associated with poor mental health, such as increased crime, low educational attainment, problematic substance use, depression and suicide.

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Appendix I Codes

Relationship between Mental and Physical Health	
Interconnected	Intertwinement
Circular	Not Addressed in System
Critical Relationship	Overall Health
Definition of MH	Patient's Understanding of the Relationship
Differing Relationship Strengths	Personal Blame
Duality	Related
Holistic	Segmented System
Independent	Society and Culture
Factors Determining One's Mental Health	
Ability to Communicate	Lifestyle Behaviours
Access to Services	Locus of Control
Age	Love
All Factors	Medical
Anxiety	Medications
Balanced Life Components	Oppression
Basic Needs	Other's MH Status
Cannot Address all Factors Affecting MH	Past Experiences
Cognition	Perception
Colonization	Personality
Comfort	Physical Health Condition
Coping	Poverty
Creative Outlets	Quality of Life
Criminal Justice System	Racism
Culture and Ethnicity	Relationship Status
Determinants of Health	Relationships
Developmental	Religion and Spirituality
Dislocation	Relocation
Education	Residential Schools
Employment	School
Environment	Self-Esteem
Expectations	Sense of Community
Family's History and Health Status	Sense of Contribution, Purpose, Belonging and Acceptance
Fear of Institutions	Sense of Normalcy
Financial Resources and Status	Sense of Security or Safety

Factors Determining One's Mental Health	
Food	Sense of Self
Gender	Social Context
Genetics and Biology	Social Support Networks
Geography	Socially Constructed
Grief	Socioeconomic Factors
Happiness	Stereotypes
History of Mental Illness	Stigma and Discrimination
Housing	Stigmatizing System
Identity	Stress
Image	Stressors
Insight	Substance Use Issues
Intergenerational Transmission	System-Related Trauma
Internal and External Factors	Systematic, Organizational or Institutional Factors
Isolation	Trauma
Knowing What Services are Available	Violence
Lack of Trust in System	Whole Being
Learning Disability	
Defining Mental Health Promotion	
Ability to Function	Mental Health Services
Acceptance	Mental Illness Prevention
Accessing Services and Resources	Moving Towards Health
Adaptive	Normalizing Experience
Addressing Determinants of Health	Participate in Community
Asking Questions, Being Supportive, Calm and Caring	Primary Health Care
Awareness of Relationship Between Mental and Physical Health	Promoting Quality of Life
Awareness, Understanding and Acceptance of Mental Health	Psychological Strategies
Being Compassionate with Oneself	Public Health
Building Capacity and Skills	Public vs. Private Mental Health Promotion
Building Relationship	Resiliency
Coping Strategies	Respect
Creating Cultural Safety	Screening
Differing Levels of Mental Health Promotion	Self-Awareness
Education	Self-Care and Self-Management

Defining Mental Health Promotion	
Empowerment	Self-Esteem and Identity
Focus on a Holistic Approach	Social Strategies
Focus on Positive Aspects of Health	Spiritual Strategies
Focus on Wellbeing	Strengths-Based Approach
Health Promoting Activities	Stress, Anxiety, Anger Management
Health Education	Support Groups
Individual Strategies	Symptom Management
Intersectoral	

Appendix J Themes

Relationship between Mental and Physical Health	
Connected	Holistic
Awareness and Understanding	Independent
System	
Factors Determining One's Mental Health	
Social	Biology
Psychological	Physical
System Related	Determinants of Health
Culture	Substance Use
Socioeconomic	Developmental
Physical Health	
Defining Mental Health Promotion	
Health Promotion and Education	Risk
Protective	System Level
Awareness and Understanding of Mental Health and Mental Health Promotion	Patient Centred
Holistic	

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