

Context & Issues:

It is widely recognized that prevention initiatives for mental disorders have positive outcomes on populations at risk of mental illness. It has also been demonstrated that mental health promotion initiatives have a wide range of health and social benefits including hope for the future, improved physical health, increased resilience and tolerance, and greater capacity for participation and productivity (Promoting Mental Health WHO 2004).

For people living with mental illness, mental health promotion also contributes to health improvements, to reducing stigma and discrimination, and to increasing understanding of mental health.

In the document entitled “Out of the Shadows at Last” (2006) Senator Kirby recommends that in order to end stigma and discrimination action must be taken on three fronts:

- 1) education and awareness (only by changing our perception, removing the social stigma and understanding more about mental illness can we as a society begin to improve the treatment and care provided to the people who suffer from a mental disorder).
- 2) media (the most effective means of spreading insightful information about mental illness).
- 3) recognition of the seriousness of mental illness by all Canadians (important to treat mental and physical illness with equal seriousness both within the medical community and in society more generally).

Research on discrimination and stigma shows that the most effective strategies combine education and personal contact with someone representing a stigmatized group. Wisconsin United for Mental Health discusses mental illness as common, real, treatable (May 2002).

Mental illness prevention and mental health promotion initiatives have a varied and broad scope, and address three levels of need in the population:

- 1) all Nova Scotians
- 2) Nova Scotians at risk of developing mental illness and
- 3) Nova Scotians with mental illness (adapted from: Making it Happen, 2001).

At each level of need, interventions focus on factors known to either

- 1) strengthen mental health, or
- 2) reduce factors known to increase risk of mental illness, or
- 3) reduce stigma and discrimination experienced by people with mental illness.

Generally the results of prevention and promotion interventions are unique in that outcomes are not evident for 2 to 3 years or longer. Research has demonstrated there is an increased cost to the public health care system when promotion, prevention and advocacy strategies are not implemented (University of Surrey 1998, National Children’s and Youth Law Centre 1997).

Context & Issues cont'd.

The evidence currently available on mental health outcomes of public policies is limited; however, recent research reports demonstrate that targeting populations (i.e. high risk individuals, vulnerable groups) at a community, provincial, or a national level has positive outcomes.

The challenge of providing evidence of the positive effects of upstream interventions for policy makers is that many of the major social determinants of mental and physical health are not amenable to randomization.

Evaluative research on mental health outcomes of behavioral, organizational, psychological, or policy options is still relatively uncommon in most countries. One reasonable approach argued for by Sturm is that there is still a valuable role for longitudinal observational studies which can inform mental health policy by providing mental health monitoring data (Sturm 1999). The call for more robust outcome evaluations does not therefore preclude the contribution that can be made from the provincial strategy as found in "Our Peace of Mind" for Nova Scotia (2004). This strategy targets priority groups with prevention and early intervention initiatives that are supported by available evidence of effectiveness. The priorities of the mental health sector are initiatives targeting individuals at risk of developing mental illness, and individuals with mental illness who are at risk of relapse. It is incumbent upon providers of mental health services to collaborate with potential partner agencies and organizations who are observational data on determinants and indicators of mental health (Herman 2001) working towards enhancing the mental health status of Nova Scotia's.

In Nova Scotia, advocacy in mental health continues to be discussed and consensus by organizations, agencies and government as to a desired approach has yet to be reached.

"Advocacy by its nature involves not only the advocate and the individual, but also various organizations, agencies, and/or government departments; each has an important role in a successful advocacy system" (Position Paper: Advocacy. Crown Copyright, Province of Nova Scotia, 2005).

The "Aim of advocacy is to place mental health issues high up on the political and community agenda and effectively convince stakeholders to act in support of mental health." (WHO 2005:191)

Nova Scotia is becoming an increasingly diverse province. The way people use health care services, access and benefit from programs and approaches to care is impacted by individual characteristics such as gender, gender identity, sexual orientation, disability, language, race, ethnicity, and cultural background (Diversity and Social Exclusion Initiative, 2004).

"Provisions of mental health care services to respond effectively to the needs of patients and their families, recognizing the racial, cultural, linguistic, educational and socio-economic backgrounds within the community (Masi, 2000).

Resources available and competing priorities from the treatment side challenge health districts/IWK. This requires districts/IWK to continue their developing additional partnerships and modifying program models to meet their needs.

Program Description:

The overall objectives of the Core Program - Prevention, Promotion and Advocacy are as follows:

- to provide information designed to enhance awareness and understanding of mental illness;
- to reduce stigma and discrimination;(see Appendix A)
- to promote mental health;
- to support HP&P and partner with the DHAs/IWK in mental health primary prevention activities directed at averting a potential mental illness;
- to lead in secondary prevention activities directed at early detection and intervention to prevent, delay onset, or mitigate a mental illness;
- to provide education and training on understanding the mental health service delivery system.

Prevention programs may be categorized according to focused outcomes:

- primordial prevention, directed at whole population
- primary prevention, directed at averting a potential mental illness
- secondary prevention, directed at early detection and intervention to prevent or delay onset, or to mitigate a mental illness
- tertiary prevention, directed at minimizing disability or avoiding relapse in those individuals diagnosed with a mental illness (see Table 1 Glossary).

[The majority of initiatives carried out by mental health services/programs will be in the area of secondary prevention and guided by Our Peace of Mind (2004)]. Maintaining good mental health may be challenging especially for those who have experienced mental illness.

Specific attention may be required to address all the determinants of health especially for housing, education and employment.

Education and training programs need to be developed through consultation and collaboration with:

- those who have experienced mental illness
- service providers and experts in the field
- community and not-for-profit groups.

Goal Statement:

Nova Scotians, including those at risk and/or living with mental illness, are supported to move toward optimal health. *(Adapted from Department of Health Promotion and, American Journal of Health Promotion).*

Initiatives will be based on a foundation that includes:

- cultural and diversity competency;
- best practice interventions; and
- quality and evaluation components

Initiatives will focus on the following:

- awareness of mental health/mental illnesses;
- reduction of stigma associated with mental illnesses; and
- early detection and minimizing disability.

Promotion, Prevention, Advocacy

Domain	Standard	Measure/Indicator	Evidence
Accessibility	A.1. Partnerships to implement promotion and prevention programs extend across all sectors including individuals, organizations and communities.(school, seniors, Acadians, School Boards, First Nations etc.)	<ol style="list-style-type: none"> 1. Current initiatives 2. Current community partnerships 	II
Appropriateness	A.2. The DHAs/IWK identify and target at risk groups in their communities, with focused, evidence-based programs to address their needs (e.g. “Your Mind Matters” ...Early Psychosis Program)	<ol style="list-style-type: none"> 1. Supporting evidence for initiative 2. Service & setting appropriate to needs of individual 	II
Accessibility Efficiency	A.3. DHAs/IWK are engaged in standardized provincial strategies with government departments and community groups.	<ol style="list-style-type: none"> 1. Consumer, family perspective of accessibility 2. most effective use of resources 	III
Accessibility	A.4. Education about mental illness, mental health and the mental health delivery system is provided at a district level for all Nova Scotians.	<ol style="list-style-type: none"> 1. Current information is available on DHA/IWK web sites 2. Information is available in print form in clinics & physician’s offices 	III
Effectiveness	A.5. Prevention and promotion initiatives include mechanisms for quality review or evaluation.	<ol style="list-style-type: none"> 1. Initiatives have clear measurable goals 2. Documented quality review or evaluation for each initiative 	II

Prevention, Promotion and Advocacy Glossary

Advocacy:

aims to support people who need assistance to express their views and to have their own stories heard and to safeguard people in situations where they are vulnerable. There are 4 types of advocacy 1) for oneself 2) for another person 3) for a group 4) for changing a system.

North Lanarkshire Council www.northlan.gov.uk

Canadian Treatment Action Council www.ctac.ca

Cultural Diversity:

refers to the unique characteristics that all of us possess that distinguish us as individuals and identify us as belonging to a group or groups. Diversity transcends concepts of race, ethnicity, socio-economic, gender, religion, sexual orientation, disability and age. Diversity offers strength and richness to the whole.

Hastings Institute <http://vancouver.ca/hastingsinstitute>

Cultural Competencies:

Is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables the system to work effectively in cross-cultural situations.

Cross et al., 1989; Isaacs & Benjamin, 1991

Determinants of Health and Population Health

Determinants of Health:

considers the entire range of individual and collective factors and conditions, and their interactions, that have been shown to be correlated with health status. Commonly referred to as the "determinants of health," these factors currently include: Social Support Networks, Education, Employment/Working Conditions, Social Environments, Physical Environments, Personal Health Practices and Coping Skills, Healthy Child Development, Biology and Genetic Endowment, Health Services, Gender, Culture. Our understanding of what makes and keeps people healthy continues to evolve and be further refined. A population health approach reflects the evidence that factors outside the health care system or sector significantly effect health.

Population Health:

is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health. *Public Health Agency of Canada 2004*

Discrimination:

refers to inequitable or unfair treatment of people with mental disorders, which amounts to denial of the rights and responsibilities that accompany full citizenship. It is a natural outgrowth of stigma. Discrimination may occur at an interpersonal level, reflecting a desire for social distance and exclusion. It may also occur at a structural level when people with mental disorders are overtly or covertly excluded from public life through a variety of legal, economic, social and institutional means.

Fink and Tasman 1992; Link and Phelan 2001.

Health Promotion:

defined as action and advocacy to address the full range of potentially modifiable determinants of health (WHO 1998). Health promotion and prevention are necessarily related and overlapping activities. Because the former is concerned with determinants of health and the latter focuses on the causes of disease, promotion is sometimes used as an umbrella concept covering also the more specific activities of prevention.

Lehtinen, Riikonen & Lahtinen 1997

There is mounting evidence that it is possible to intervene at several levels, from local to national, to improve health (Benzeval et al., 1995). The factors over which individuals have little or no control require the collective attention of a society as encapsulated by the Ottawa Charter of Health Promotion (WHO, 1986). The five action strategies identified by the Charter remain today the basic blueprint for health promotion in many parts of the world.

Promoting Mental Health Concepts-Emerging Evidence-Practice WHO 2004

Mental Health:

means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental. *CMHA*

Prevention:

refers to all the efforts involved in improving population health and preventing disease, disability, and premature death. Prevention is most easily understood as actions and interventions along a continuum of health, from wellness to illness. As such, disease prevention and disease management are not mutually exclusive. Prevention activities are generally categorized at the levels of primary, secondary, and tertiary

Primordial prevention:

is a significant component of prevention. Primordial prevention refers to negating the effects of social determinants of health and changing the quality of exposure to social determinants of health.

Table 1: Levels of Prevention *

Level of Prevention	<i>Primordial Prevention</i>	<i>Primary Prevention</i>	<i>Secondary Prevention</i>	<i>Tertiary Prevention/ Disease Management</i>
Targeted Population	Whole population	Whole population – Universal and targeted	At-risk individuals and groups	Individuals with established disease
Intervention Objectives	Preservation and promotion of healthy determinants and reduction of unhealthy determinants	Prevent individuals and groups from becoming “at risk.” Modify risk factors/contexts	Lower incidence of established cases of disease	Eliminate or reduce long-term impairments, disabilities, and complications
Nature of Intervention	Change the quality of determinants of health. Modify the effects of determinants of health.	Promotion of healthy behaviors and supportive environments across the life span.	Periodic health examinations. Screening. Early intervention. Modification of risk factors.	Treatment. Self-management counseling and education. Rehabilitation.

** HEALTH PROMOTION*

Adapted from National Public Health Partnership (Australia). Preventing Chronic Disease: Strategic Framework. 2001

Quality of Life:

ability to achieve satisfaction in key life domains including social relationships and support, financial stability, physical, social and emotional health, control over life choices, community involvement and personal empowerment.

Performance indicator for Mental Health Services and Supports 2001

Risk factors:

circumstances that make a particular population at greater risk for development of a disorder. Risk factors may be biological or social

characteristics, or a combination of the two.

Stigma:

someone who appears to be different than us, we may view him or her in a negative stereotyped manner. People who have identities that society values negatively are said to be stigmatized.

Adapted from CMHA

Prevention, Promotion and Advocacy Bibliography

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