



Our Peace of Mind

Mental Health Promotion, Prevention and Advocacy Strategy and Framework for Nova Scotia

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We also particularly acknowledge the framework documents provided by the Northern Ireland Task Force on Mental Health Promotion, the New Zealand Clearing House for Health Outcomes and Health Technology Assessment, the UK NHS Centre for Reviews and Dissemination, the ‘see me’ campaign on stigma of the Scottish Executive as well as A Best Practices Approach to Health Promotion, Nova Scotia. We also acknowledge reports on suicide from the Injury Prevention Strategy of Nova Scotia, Quebec’s Strategy for Preventing Suicide and the Alberta Heritage Foundation for Medical Research.

TABLE OF CONTENTS

I. Executive Summary	5
II. Introduction	6
III. Mental and Emotional Health / Health Promotion	9
IV. Stigma and Discrimination	6
V. Suicide Prevention	14
VI. Strategic Framework for Implementing Mental Health Promotion, Prevention and Advocacy	17
VII. Tables	
Table 1....Health Indicators Framework	23
Table 2....Core Standards 2002	24
VIII. Appendices	
Appendix 1....Terms of Reference	25
Appendix 2....CCHSA for Nova Scotia	27
Appendix 3....Evidence Good Mental Emotional Health	29
Appendix 4....Increased Risk for Secondary Prevention	30
Appendix 5....Emotional Mental Health	31
Appendix 6....Mental Health Promotion Activities for Specific Age Groups	33
Appendix 7....WHO –Stats Canada	41
Appendix 8....NSCNAS Recommendations – Suicide Prevention	46
Appendix 9....Characteristics of People at High Risk	53
IX. References	54
X. Contributors	60

I. EXECUTIVE SUMMARY

Bland and Dufton in their report "Mental Health: A Time for Action" noted that mental health services throughout the province recognize the importance of promotion, prevention and advocacy initiatives for mental and emotional health. Historically the issues most frequently raised have been resources and the lack of expertise to meet the need of this core program. They also reported that the majority of mental health promotion activities being offered by mental health services lack focus and are merely reactive responses to community requests.

This document provides the background information related to prevention, promotion and advocacy of mental and emotional health. A service model, strategic framework including a process and templates to implement promotion, prevention and advocacy activities are provided.

It is recommended that the service model, strategic framework, including the process and templates, be approved for all mental, emotional health promotion, prevention and advocacy activities for the province.

II. INTRODUCTION

Publicly funded health services in Nova Scotia operate a wide variety of programmes, which, if not aimed directly at improving mental health and preventing mental illness, certainly have an impact in that area. This includes areas such as: maternal and child health, childhood immunization program, folic supplement programs for women of child bearing age, programs to reduce the rate of teenage pregnancy, and programs which try to ensure the well being of single teenage mothers. The integration of health into schools is well developed in some parts of the province but less so in others and similar comments would apply to the availability of counselling and psycho-educational assessment services within the educational system.

The 'Bland Dufton Report' on mental health services in the Province in 2000 highlighted the need for [1]:

- public information on mental illness covering a number of areas including information about specific diseases, particular programmes and their accessibility, as well as public information and activities to address stigma;
- a more integrated and proactive approach to mental health promotion and revention.

The report observed that although district mental health services recognised the importance of mental health promotion and prevention, they had neither sufficient time nor expertise to undertake initiatives in the area.

In response to this report, the Department of Health committed itself to positive action on mental illness as a leading cause of ill health and disability. A Promotion, Prevention and Advocacy Core Program Standards Subcommittee undertook initial work. In September 2003, the Mental Health Steering Group of the Department of Health commissioned a provincial working group to develop a systems model and strategy for mental health promotion with targets for implementation. The purpose was:

To develop and recommend a provincial strategy for promotion, prevention and advocacy of mental health problems to guide interventions across Nova Scotia built on best practice and evidence. (See Appendix 1 for Terms of Reference)

Many initiatives bring together local agencies and services across sectors in collaborative approaches to meet the needs of communities.

III. MENTAL AND EMOTIONAL HEALTH / HEALTH PROMOTION

Mental and emotional health is a positive sense of well being and an underlying belief in our own and others' dignity and worth [2]

Mental health problems are one of the leading causes of morbidity and disability in the world. According to World Health Organisation figures, depression is the fourth-leading cause of disability worldwide, and is forecast to become the second-leading worldwide cause of disability by 2020 [6].

In 2003, the Canadian Community Health Survey found that even though mental illness was as common as other chronic diseases such as cardiovascular disease or cancer, only 40% of people sought treatment. (More details of these results can be found in Appendix 2).

Mental health promotion has a wide range of health and social benefits - improved physical health, increased resilience, greater tolerance, participation and productivity. Promotion also contributes to health improvements for people living with mental health problems and challenges stigma and discrimination, as well as increasing understanding of mental health issues.

The following definitions have been used to describe these concepts:

Mental Health Promotion: any action taken to maximize mental health and well being among populations and individuals [3]. Mental Health promotion activities may be directed not only at those who are well but also individuals or groups at risk, or already experiencing illness.

Prevention: refers to 'interventions that occur before the initial onset of a disorder' to prevent the development of disorder [3]. The goals are to reduce incidence and prevalence, delay onset or mitigate the problem or to minimize disability and avoid relapse. As such, prevention activities include:

- Primary Prevention - directed at averting a mental health problem. Interventions may be aimed at the whole population (universal), at risk groups (selective) or individuals displaying signs and symptoms that are not yet diagnosable (indicated).
- Secondary Prevention - directed at early detection and intervention to delay onset or mitigate a mental health problem.
- Tertiary Prevention - directed at minimizing disability and avoiding relapse in individuals with a mental health disorder.

Appendix 3 summarizes some of the activities that evidence shows support good mental and emotional health across the lifespan.

Appendix 4 identifies situations at various stages of the life span that create increased risk of mental health problems and for which Secondary Prevention measures may be appropriate.

Any strategy directed at promotion, prevention and advocacy activities should be based on a population health approach and be cognizant of the impact of all of the Determinants of Health as identified by Health Canada. These include:

- income and social status;
- social support networks;
- education;
- employment and working conditions;
- social environments;
- physical environment;
- personal health practices and coping skills;
- culture;
- healthy child development;
- health services;
- gender;
- biology and genetic endowment [98].

In developing health promotion approaches, The Ottawa Charter provides key strategy areas to consider. A combination of these strategies has been shown to be most effective and requires collaborative intersectoral approaches. The five strategies are:

- Creating supportive environments;
- developing personal skills;
- building healthy public policy;
- strengthening community action;
- reorienting health and other services [98].

Health promotion and prevention activities often have overlapping outcomes. For example, a strategy designed to promote healthy childhood development or good parenting skills (promotion) may also prevent the onset of behavioural problems (prevention).

The Standards (See Table 2) outline the goals of promotion, prevention and advocacy. It also points out that the priority of the public mental health sector is to focus on groups at risk of developing a mental health problem and vulnerable individuals with mental health problems. This places their mandate within the domains of secondary (early intervention) and tertiary prevention. The standards also suggest that providers of mental health services need to collaborate with other stakeholders who have as a primary focus the enhancement of the health status of the whole population, i.e. health promotion and primary prevention.

Mental and emotion health promotion aims to enhance factors conducive to positive mental and emotional health while taking into consideration the factors that put mental health at risk or are barriers to positive mental health. There will always be a range of internal and external factors that can *enhance or protect* mental health and well being or increase *vulnerability* to mental ill health or disability.

Factors associated with mental, emotional health include the following:

Risk factors [11-13]:

- social disadvantage (e.g. low household income, limited parental education, poor living standards) ;
- family functioning (e.g. marital discord, parental emotional problems, punitive child-rearing, abusive experiences, inadequate parental supervision or discipline, impaired parent-child relationships, death and bereavement in the family, risk behaviour of family such as substance use);
- individual factors (e.g. early onset of behavioural problems and difficulties, stress, personality (such as rebelliousness), attitudes (e.g. towards substance use), being female (e.g. for depression, anxiety and eating disorders));
- family history (e.g. behavioural and genetic inheritance);
- school factors (e.g. cognitive delays in childhood, school culture, disciplinary practices, academic failure, low intelligence, low commitment to school);
- peer factors (e.g. peer-group influences, values and norms, related to peer pressure, modelling, and rejection);
- community (e.g. impoverished neighbourhood, high crime rate, ineffective social policies, laws and norms, availability of substances or weapons);
- media (e.g. television violence, alcohol advertising and media presentations which normalise anti-social behaviours may increase risk, but are likely to make relatively minor contributions).

Protective factors [13]:

- intelligence and problem-solving abilities;
- external interests and affiliations, social competence, good peer relationships;
- parental attachment and bonding;
- early temperament and behaviour.

The overlap of risk factors, and co-morbidity of mental illness, suggests that early prevention programmes aimed at reducing risk may be more effective if directed toward general mental health rather than focusing on specific disorders. Mental health promotion approaches therefore aim to:

enhance protective factors by strengthening the ability of individuals, families or communities to cope with events that happen in their everyday lives, through:

- facilitating self-help networks;
- increasing coping skills;
- improving quality of life and feelings of satisfaction;
- enhancing self esteem;
- strengthening social support.

decrease risk factors for poor mental health, such as;

- anxiety,
- depression,
- stress and distress,
- helplessness,
- situations of family abuse and sexual abuse,
- substance abuse,
- violence and
- social isolation,

and reduce inequities among populations, such as;

- lack of access to services because of poverty or geographical location,
- discrimination on grounds of gender, sexuality, race or disability,
- community insecurity,
- poor quality housing
- unemployment.

The promotion of mental and emotional health will result in the achievement of the following goals:

- to promote mental and emotional well-being with the general public, those at risk or more vulnerable, and those with identified mental health problems, their carers and families;
- to contribute to a reduction in the incidence and impact of mental and emotional distress, anxiety, illness and suicide;
- to increase public and professional awareness of mental health issues.
- to ensure that mental and emotional health is supported at all levels of policy making and strategic planning;
- to increase knowledge of effective practice in mental and emotional health promotion;
- to make information on the mental and emotional health status and needs of the population more available and accessible;
- to ensure service providers involved in the promotion of mental and emotional health are knowledgeable and skilled.

(For further information on Mental and Emotional Health Promotion see Appendix 5)

Several effective interventions can help promote mental health and prevent mental health problems in those at high risk throughout the life span such as [2, 16, 17]:

- high quality pre-school education and support visits for new parents can improve mental health in children and parents in disadvantaged communities [17];
- school-based interventions and parent training programmes for children showing behavioural problems can improve conduct and mental well being [18];
- mental health problems in children of separating parents can be reduced by providing cognitive skills training and emotional support [16];
- social support and problem solving or cognitive-behavioural training in the unemployed can improve mental health and employment outcomes [16];
- mental health problems often experienced by long-term carers can be prevented by

respite care and some forms of psychosocial support [16].

Mental health promotion is most effective when information and support are available, and the messages reinforced, in a wide range of settings. For example, in the media, in the workplace, in primary care, in schools, libraries, places of worship, recreation centres and other community settings.

The following approaches are effective [2, 10,16]:

- promoting good social relationships, for example, through social skills and assertiveness training, as well as communication and relationship skills;
- developing effective coping skills. These include problem solving skills, cognitive skills and parenting skills;
- providing social support and making social changes. Examples include: changing school attitudes regarding bullying, home visits from health workers to support new parents, supporting bereaved families and supporting widows.

(Further information on Mental Health Promotion activities for specific age groups can be found in Appendix 6)

IV. STIGMA AND DISCRIMINATION

There is a high level of stigma associated with mental health problems and interventions to counter stigma of mental illness represent a particular aspect of tertiary prevention. Stigma comes from a Greek word meaning a ‘mark of shame or discredit.’ It is an attempt to label a group of people as less worthy of respect than others [68-71].

People with mental health problems are often stigmatised due to lack of knowledge, misinformation and fear. Stigma against people with a mental illness often involves negative labels, or inaccurate and offensive representations in the media, portraying them as violent, comical or incompetent.

Some authors prefer the use of the word discrimination as being more appropriate in describing the problems faced by people with mental illnesses [71]. The disability rights movement have argued that people with disabilities do not find the concept of stigma to be a useful one, as stigma tends to put the focus on the ‘branded’ person while the concept of discrimination puts the focus on the individuals and institutions that practice it. Although these were valid arguments, we have used the term ‘stigma’ in this paper as this more commonly used by workers in this area.

A Report of the Minister of Health’s Advisory Council on Mental Health in British Columbia identified four major stereotypes or emotional reactions to people with mental illnesses that fuel stigma and discrimination [71]:

- **fear:** fear of violence and unpredictability, and fear of what mental illness represents in the way it attacks the faculties (emotions, thoughts, behaviours, self concept) and the parts of us (the brain and mind) that define our very humanity;
- **blame:** the view that people with mental illnesses have brought their problems upon themselves;
- **poor prognosis:** the view that there is little hope for recovery from mental illness;
- **disruption in social interaction:** the view that people with mental illnesses are not easy to talk to and have poor social skills.

Some people affected by mental illness say that the effects of stigma can be as distressing as their symptoms. Stigma can be barrier to individuals and their families from getting the help they need due to the fear of being discriminated against In a recent Scottish Executive survey, half of all respondents said that they would not want anybody to know if they developed a mental health problem. Nearly half of respondents in the same survey said that they thought media portrayal of people with mental health problems was more negative than positive [69]. This has negative affects in many areas. People with serious mental illness have the highest rate of unemployment and underemployment of all people with disabilities, at a rate of around 85% [71]. When people with mental illness find work, that work tends to be sporadic, poorly paid and lacking employee benefits [71]. They all too often find themselves involved in the “three F” occupations: food, filing and filth [71]. Mental illness is the second leading source of workplace

discrimination complaints. Surveys have consistently found that anywhere from one-third to one-half of people with mental illnesses report being turned down for a job for which they were qualified after their illness was disclosed, or had been dismissed from their jobs, and/or forced to resign as a result of their mental illness. Figures are not dramatically lower for employment within mental health agencies or for volunteer positions both inside and outside the mental health field [69-71].

Contrary to common myths, schizophrenia is not a split personality, nor does the behaviour of people with this diagnosis swing dramatically between ‘normal’ and dangerous. People with schizophrenia are rarely dangerous, but are experiencing things that can be extremely unpleasant and frightening for them. Recovery rates for mental health problems are between 70% and 80% [69-71].

There have been a number of campaigns overseas to address stigma. In England, Changing Minds is a five-year anti-stigma campaign organised by the Royal College of Psychiatrists [72]. In Australia, SANE runs a stigma-watch campaign [73].

The Scottish Government is running a similar campaign called ‘see me’ [68].

Figure 1

Scottish media guidelines [68]

Get on good terms

No Offence

Mental ill health/mental health problems	Preferred to mental illness, which can imply a severe, diagnosed and enduring condition
Person with a mental health problem	Generally used to refer to a person with a diagnosed condition, or for whom problems with their mental health have a significant impact on their lives. Preferred to ‘patient’, ‘sufferer’, ‘victim’ etc.
Person with/experiencing schizophrenia, depression, etc.	Preferred to a ‘schizophrenic’, ‘depressive’, ‘anorexic’ etc. See the person, and not a label, by using more positive and sensitive terms when referring to them

No Go

Demented/loony madman/maniac nutter/schizo	Harmful, outdated and offensive terms. Not to be used in any context as they perpetuate ignorance and lead to stigma
Psychotic	Should never be used as a general description of someone with mental health problems. Its only correct use is as a specific description of the symptoms of psychosis
Split personality	A common myth associated with the symptoms of schizophrenia that people swing between being ‘normal’ and dangerous. This is rarely the case, although they may be experiencing very unpleasant or frightening thoughts

In Pennsylvania, the Open Minds Open Doors campaign revolves around the following four key messages about stigma and discrimination [70]:

- people who have mental illnesses have the same needs as everyone else;
- people who have mental illnesses can and do recover and live productive lives;
- people who have mental illnesses make valuable contributions to society;
- discrimination against people who have mental illnesses keeps them from seeking help and violates their basic human rights.

These campaigns have many features in common. These include information leaflets for the public and media about mental illnesses. In Australia and Scotland this is backed up with a monitoring programme that encourages people to report examples of stigmatising language in the media, supplemented with letter templates for people to write to the perpetrator [69, 73].

The Pennsylvanian campaign has also produced a Mental Health in the Workplace booklet. This is a guide for employers that details the benefits of hiring people who have mental illnesses. It provides suggestions for recruiting and retaining people who have mental illnesses, outlines action items for educating employees about mental health issues and creating a "healthy" environment, and demonstrates how businesses can save money in the process. A version of the guide is also available for mental health providers as employers.

Although it is hard to evaluate the effect of these programmes, the dissemination of media guidelines on the portrayal of suicide has been shown to be effective (see below). A study in Alberta showed that it was possible to improve one newspaper's portrayal of mental illnesses, specifically, schizophrenia [74]. Investment in media guidelines for the portrayal of mental illness would be a cost-effective initial step in an anti-stigma campaign in the Province. Similarly the employment guide has some examples of best practice and effect on outcome.

V. SUICIDE PREVENTION

The following components are included [93]:

- Prevention: “suicide prevention includes any self injury prevention or health promotion strategy generally or specifically aimed at reducing the incidence and prevalence of suicidal behaviours (i.e. reducing risk)”[93].
- Intervention: “suicide intervention includes early recognition and assessment of risk, immediate response, resource referrals, and follow-up management and treatment of individuals at risk of suicide”
- Postvention: “refers to the general care and support or special treatment needed by survivors of a suicide”.

The following definitions of suicidal behaviours are adapted from the Association québécoise de suicidology (AQS) and American National Strategy for Suicide Prevention [75,76]:

- **suicidality**: a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide;
- **suicidal ideation**: self-reported thoughts of engaging in suicide related behaviour;
- **suicidal behaviour**: a spectrum of activities related to thoughts and behaviours that include suicidal thinking, suicide attempts, and completed suicide;
- **suicidal act** (also referred to as suicide attempt): a potentially self-injurious behaviour for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries;
- **suicide**: death from injury, poisoning, or suffocation where there is evidence that a deliberate self-inflicted act lead to the person’s death;
- **self harm/self injury**: the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

(Statistics from the World Health Organization and Statistics Canada and other information can be found in Appendix 7)

Although a large number of interventions have been suggested for the prevention of suicide, no single approach has produced unequivocal results. We review the approaches for which there is the most evidence of effectiveness in the following areas [77, 94-96]:

1. Primary care
2. Secondary care
3. Public health measures
4. Community settings

Primary and Community Care:

20 to 25% of those committing suicide have contact with someone on primary care in the week before suicide. Although evidence for the effectiveness of educating general practitioners in the diagnosis and treatment of depression in suicide rates has been equivocal, particular strategies that have been suggested include: an increased reliance on therapeutic doses of newer, safer antidepressants at the expense of older tricyclics and tranquillisers, and limiting quantities of potentially toxic drugs [94]. Improvements in the treatment of depression would include prescription for at least six months, longer-term prophylaxis with antidepressants or lithium for severe cases, and increased awareness of suicide in those at high-risk [93].

Secondary Care Setting:

Of completed suicides, 30-47% have a history of previous deliberate self-harm. A quarter of those committing suicide are under current or recent psychiatric care. Screening of patients to identify those at the greatest risk for suicide, the treatment of suicidal patients and multidisciplinary audit of suicides are therefore important in secondary care settings. Other strategies include [76, 94-97]:

- maintenance therapy for major affective disorder;
- a ‘Green card’ scheme where all patients with a history of self-harm are given an emergency contact card;
- problem-solving therapy;
- flupenthixol treatment for recurrent self-harm;
- dialectical behavioural therapy for female patients with borderline personality disorder and recurrent self-harm;
- Cognitive Behaviour Therapy for repeated suicide attempts.

Public Health Measures:

There is evidence that the availability of particular methods is the greatest influence on suicide rates. Limiting access to means includes the changes to car exhausts such as fitting catalytic converters and selling over the counter drugs such as analgesics in smaller packages [94].

Guidelines on the reporting of suicide in the media currently exist in Australia as restricting the reporting of a particular method leads to a reduction in the number who use this means [94].

Other Public Health approaches such as crisis lines, school-based screening and public education have produced equivocal results because high-risk groups do not use them.

Community settings

Detection of suicidal behaviour in the community depends on recognising a change in a person's mental state or behaviour, especially if they are known to be a risk. Warning signs of impending suicide by some young people may include extreme changes in behaviour, suicidal threats or statements, and signs of depression. Understanding the implications of such changes and knowing how to access help are important for schools, the workplace, the community and social services. Programmes for teachers and others in contact with young people aimed at highlighting or educating about risk factors and warning signs have shown positive results. Enabling rapid access to support services for those who are contemplating suicide is vital. However it should be recognised that it is not always possible to identify young people at risk or prevent a suicide. Problems may not be overtly obvious or evident in some young people under stress.

Current evidence is inadequate to support school-based suicide prevention programs because of the uncertainty regarding their effectiveness and safety. Programmes should therefore be restricted to at-risk populations [77]. Coroners, police officers and prison officers come face to face with suicide and the suicidal in their daily professional lives. Sensitivity and care of bereaved or distressed friends and relatives should be an essential element of their training, as should the recognition of and response to suicidal behaviour. They also have an important role to play in developing and maintaining the information and information systems around suicide while ensuring security and confidentiality. Other groups who may come into contact with people at risk for suicide include the clergy, social services, local government services and non-statutory agencies

Implications

Systematic reviews of the prevention of suicide have therefore suggested that the following interventions show most promise and would be most amenable to evaluation [76, 94-97]:

- the development of locally agreed guidelines for the assessment in primary and secondary care of suicide risk in patients contemplating deliberate self-harm;
- the development of guidelines for follow-up of all inpatients discharged from hospital including notification of general practitioners with 24 hours of discharge;
- increased awareness in health and social services of high risk groups such as those with drug and alcohol problems;
- a review of prescribed medication of all patients who have a history of deliberate self-harm;
- limiting quantities of over the counter medicines such as aspirin and paracetamol, and prescription quantities of particularly toxic drugs;
- reinforcement of guidelines on the reporting and showing of actual or fictionalised suicide
- modification of car design by having catalytic converters fitted in cars sold before these were compulsory and motor vehicles equipped with devices that would switch off the motor whenever the level of carbon monoxide in the vehicle exceeds a certain level;
- easier access for those who exhibit self harm using an emergency contact card in addition to standard care, the 'green card scheme';
- awareness of guidelines for the assessment of suicide risk and high risk groups at potential points of contact, including general practitioners, district hospital staff, school teachers, social welfare, farmers federation and aa. given the high risk groups previously identified, this plan should begin by targeting gatekeepers in contact with:
 - adult men (union representatives, workers in employment centres, etc.);
 - older men (family helpers, golden age associations, other associations that work with the elderly);
 - young people with unhealthy lifestyles and no sense of belonging to a life environment, workplace or school.

(Recommendations of NSCNAS February, 2004 can be found in Appendix 8)

VI. STRATEGIC FRAMEWORK

FOR IMPLEMENTING MENTAL HEALTH PROMOTION, PREVENTION AND ADVOCACY

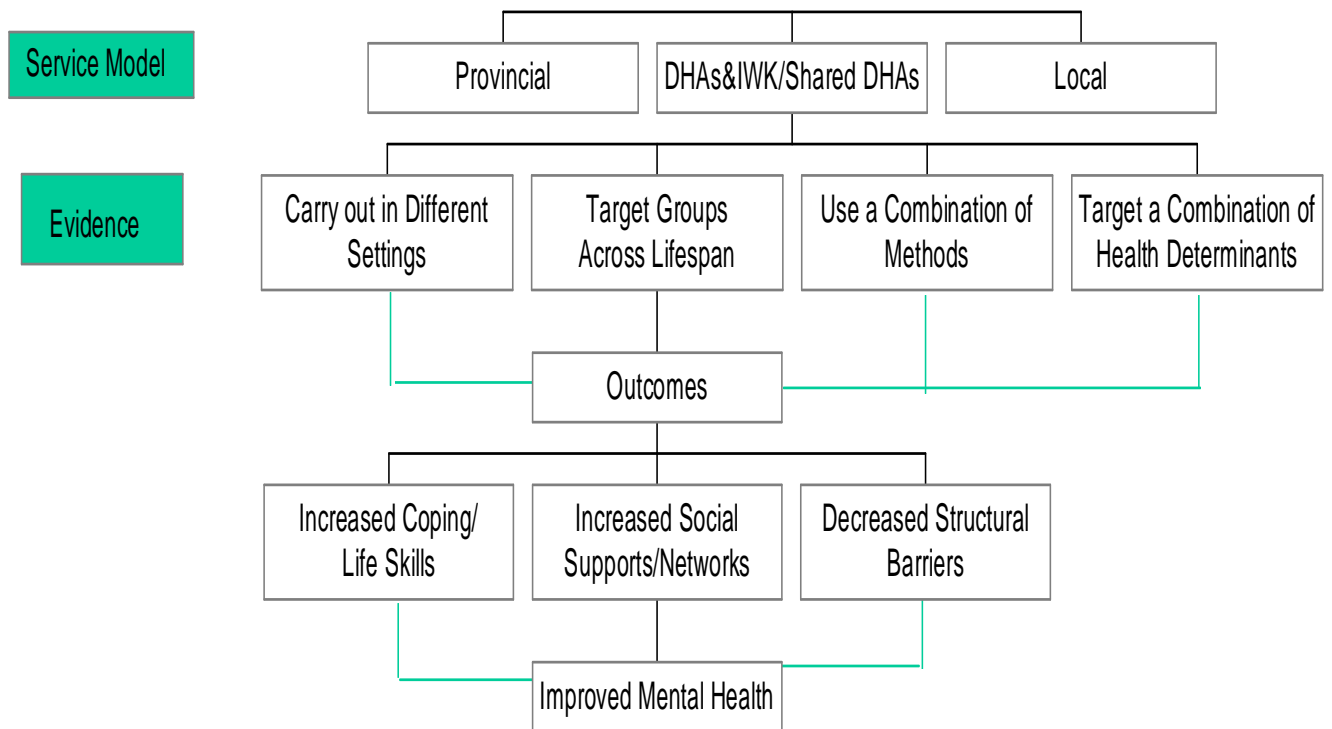
Analysis of promotion and prevention programs internationally provides evidence that the most effective strategies have the following elements in common:

- identified roles, responsibilities and accountabilities across multiple sectors, e.g. province, districts, local community;
- strategies target different settings, groups across the life span and use a combination of methods to target a mix of the determinants of health;
- improved outcomes in the three primary areas:
 - social supports and networks
 - structural barriers
 - coping and life skills

These elements and the relationships between them are represented in the following figure and can be used as an umbrella framework when designing strategies to target specific populations.

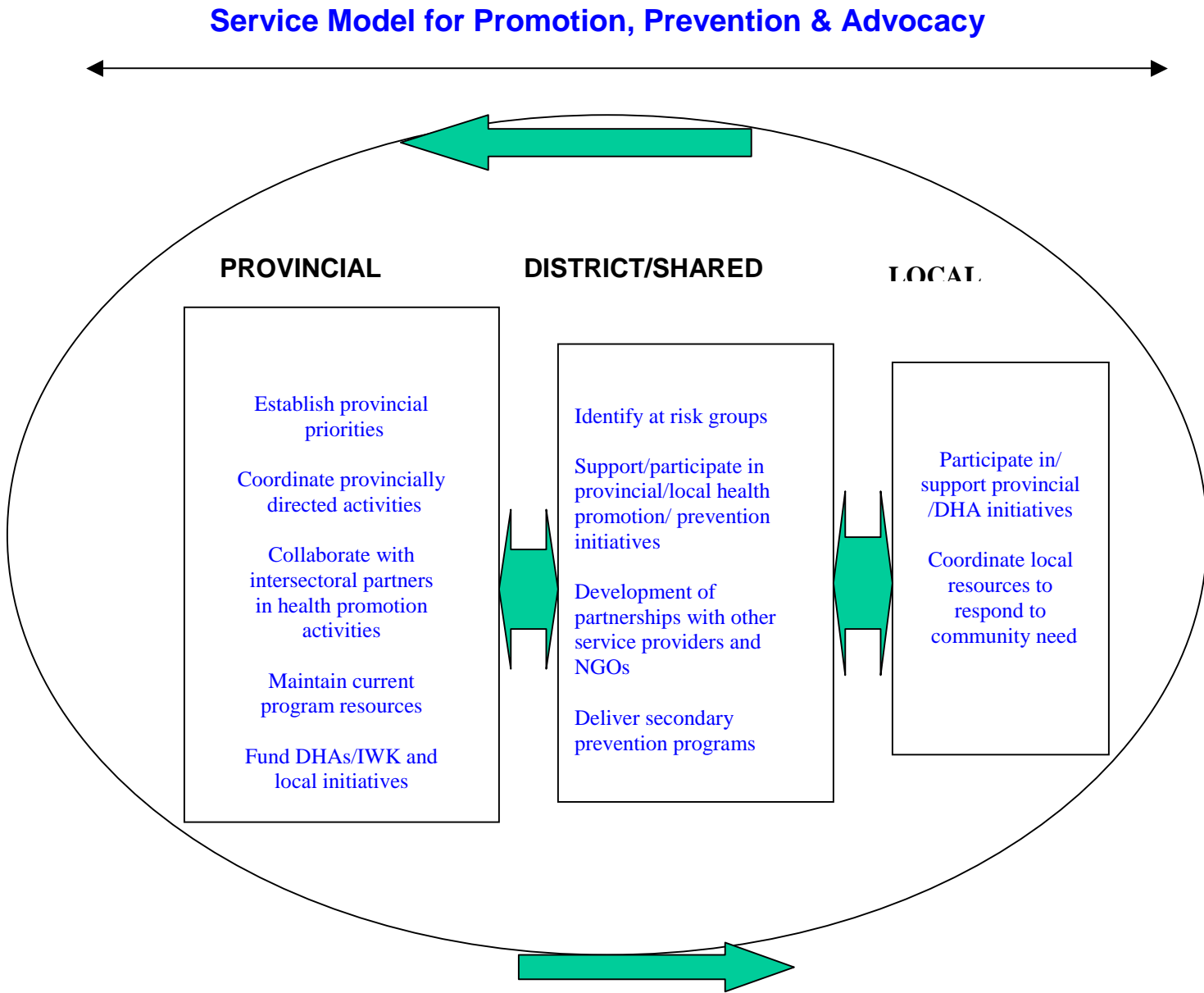
Figure 2

Framework for Promotion, Prevention, Advocacy



The Promotion, Prevention and Advocacy Service Model (Figure 3) represents the first level of the framework and outlines the roles and responsibilities of the various stakeholders.

Figure 3





Implementing a strategy will require a process to ensure all elements of the framework are present. Figure 4 represents the steps in such a process.

Figure 4



A series of templates have been developed to facilitate utilization of this process.

Template 1

Assessment Phase: Promotion, Prevention Strategy in Mental Health

Lifespan	Identified High Risk Groups	Identified Evidence Based Interventions	Process & Outcome Indicators (Based on Determinants of Health)	Identified Settings for Intervention Delivery	Identified Potential Partnerships
Perinatal 0 - 2 years					
Pre-school 3 - 4					
Children 5 - 12					
Adolescent 13 - 18					
Young Adult 19 - 25					
Adult 26 - 64					
Senior 65+					

Template 2

Planning Phase: Promotion, Prevention Strategy in Mental Health

Lifespan	Priority Target Groups	Current Programs/ Strengths (carried out by other departments/ agencies as well as within Health)	Gap Areas	Recommended Program/Action	Provincial, DHA, Local Level Responsibilities	Appropriate Partnerships
Perinatal 0 - 2 years						
Pre-school 3 - 4						
Children 5 - 12						
Adolescent 13 - 18						
Young Adult 19 - 25						
Adult 26 - 64						
Senior 65+						

Template 3

Evaluation Phase: Promotion, Prevention Strategy in Mental Health

Lifespan	Process and Outcome Indicators	Data required to measure outcomes	Data Sources	Responsibility for gathering data	Responsibility for data repository, analysis and report.
Perinatal 0 - 2					
Pre-school 3 - 4					
Children 5 - 12					
Adolescent 13 - 18					
Young Adult 19 - 25					
Adult 26 - 64					
Senior 65+					

Table 1 (CIHI 2002) [5]

Table 2 Health indicators framework (CIHI 2002) [5]

Well-Being	Health conditions	Deaths	Human function
<input type="checkbox"/> Self-rated health <input type="checkbox"/> Self-esteem	<input type="checkbox"/> (BMI <input type="checkbox"/> RA/OA <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chronic pain <input type="checkbox"/> Chronic pain <input type="checkbox"/> Depression <input type="checkbox"/> Low birth weight <input type="checkbox"/> Cancer incidence	<input type="checkbox"/> Perinatal mortality <input type="checkbox"/> Life expectancy <input type="checkbox"/> Mortality crude counts/rates, age-SMRs: <input type="checkbox"/> Potential years of life lost (PYLL) rate	<input type="checkbox"/> Functional health <input type="checkbox"/> Two-week disability days <input type="checkbox"/> Activity limitation <input type="checkbox"/> Conditions causing activity limitation <input type="checkbox"/> Disability-free life expectancy <input type="checkbox"/> Disability-adjusted life years <input type="checkbox"/> Health expectancy

Well-being	Physical, mental and social well-being	Self-rated health Self-esteem
Health Conditions	Alterations of health status, distress, ADL, HS use e.g. disease, disorder, injury or trauma, or other health-related states (pregnancy, aging, stress, congenital anomaly, or genetic predisposition (WHO)	Arthritis Diabetes Chronic pain Depression Food/waterborne diseases Injury hospitalisation
Human Function	Levels of human function lead to consequences of disease, disorder, injury and other health conditions.	Functional health Disability days Activity limitation Health expectancy
Deaths	Age-specific and condition specific mortality rates	Life expectancy Potential years of life lost

Table 2 (Core Standards 2002) [4]

Domains (CCHSA)	Standards Statements	Nature of Evidence
Accessibility	A.1. A provincial strategy for secondary prevention of mental health problems exists, developed with stakeholder involvement including participation by the DHAs and the IWK in the development and implementation of the strategy.	IV
Appropriateness	A.2. The DHAs and the IWK identify and target high risk and vulnerable groups in their communities, with focused, evidence-based programmes to address their needs.	IV
Efficiency	A.3. Partnerships to implement promotion, prevention and advocacy programmes extend across all sectors including individuals, organizations and communities.	III
Accessibility	A.4. Education about mental illness, mental health care and the mental health delivery system is provided at a district level for individuals, families, staff and public.	III

APPENDIX 1

TERMS OF REFERENCE

PROVINCIAL PROMOTION NETWORK, and PREVENTION, ADVOCACY WORKING GROUP

Background:

Promotion, prevention and advocacy is one of the core programs of Nova Scotia's mental health system. System standards for this core program were developed by the Promotion, Prevention and Advocacy Subcommittee of the Core Program Standards Working Group in 2003 and outlined the need for a provincial strategy for secondary prevention to guide the work of the DHAs and the IWK. This provincial strategy must now be developed so that the standards can be implemented.

There is a logical overlap between promotion, prevention and advocacy and the work that had been initiated under the Anti-stigma Working Group.

A new Working Group is being established to build on the work of the Promotion, Prevention and Advocacy Subcommittee and the Anti-stigma Working Group.

Purpose:

To develop and recommend a provincial strategy for promotion, prevention and advocacy of mental health problems to guide interventions across Nova Scotia built on best practice and evidence.

Functions:

- Recommend a systems model for Secondary Prevention, Promotion, Advocacy and Public Awareness.
- Identify high risk groups for mental health issues.
- Identify best practice interventions/strategies.
- Collate resource materials with recommendations for housing, dissemination.
- Recommend priority groups for consideration by DHAs.
- Recommend provincial strategies to deal with promotion, advocacy and stigma, including such things as public information about mental health care and the delivery system and provider education and training.
- Recommend evaluation protocol(s) for projects and strategies.

Membership:

- Representatives from previous Promotion, Prevention and Advocacy Core Program Standards Subcommittee
- Representatives of previous Anti-Stigma Working Group
- Representatives from Consumer, Family and Community Working Group
- Representative from the Monitoring Mental Health of Nova Scotians Working Group
- Membership representing clinical, academic, administrative stakeholders
- Department of Health

This membership should represent a balance of urban and rural districts, the IWK, consumers and advocacy groups.

Reporting Relationship:

Reports through the Provincial Steering Committee to the Executive Director, Mental Health Services.

Resources:

Staff support supplied through the Department of Health to include: meeting secretariat, research, report writing and project management.

Reasonable expenditures incurred by members involved in the Prevention, Promotion, Advocacy Working Group are reimbursed by the Department of Health.

Meeting Frequency:

At least every two months or more frequently at the call of the Chairperson.

Deliverables:

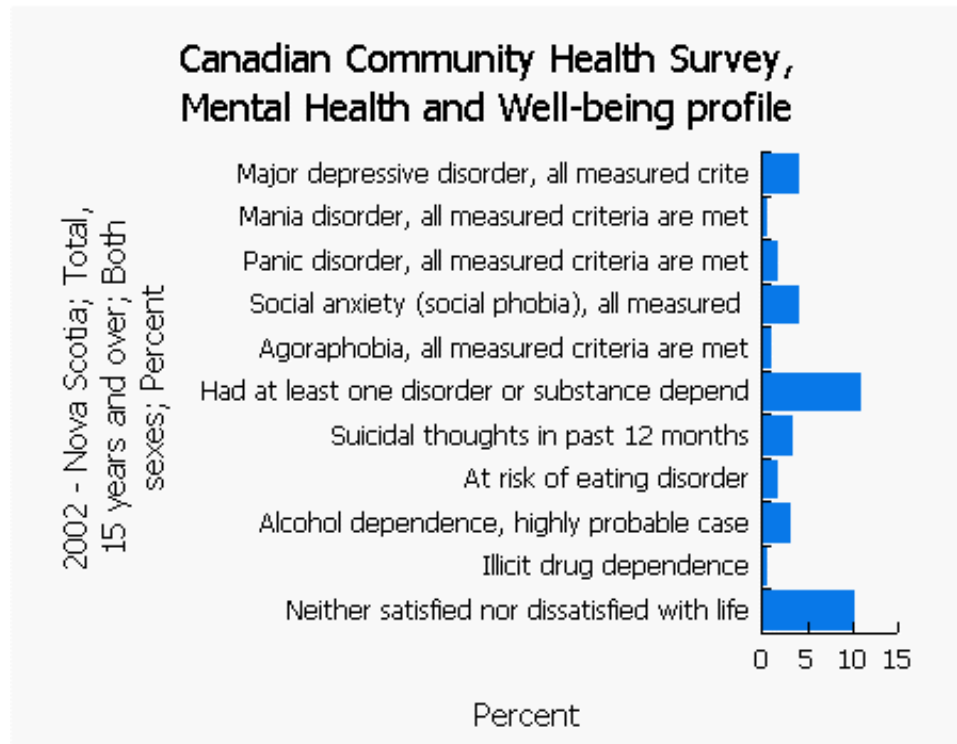
- Recommend systems model
- Recommend a provincial strategy for prevention that is targeted and evidence-based
- Identify high risk groups with recommended priorities
- Recommend resource materials and housing and dissemination mechanisms
- Recommendations for provincial strategies for promotion, advocacy and stigma
- Recommend evaluation protocol(s) for projects / strategies

APPENDIX 2

Canadian Community Health Survey for Nova Scotia

Figure 1 shows the results from Nova Scotia.

Figure 1



Acceptability, availability and accessibility are the barriers people face to seeking help for a mental disorder. Acceptability can be related to perceived quality of treatment, or stigma and discrimination. Inaccessibility may be due to difficulties in locating a family practitioner or mental health clinician. About one-third of people who reported experiencing feelings and symptoms of a mental disorder or substance dependence saw or talked to a health professional during the 12 months prior to the survey. Among those who reported a disorder, family physicians were the most commonly used professional resource - close to 26% of affected individuals consulted with their doctor. Psychiatrists were consulted by 12% of those who reported disorders and psychologists were consulted by just over 8%. Young people were least likely to seek care; just a quarter of affected young adults reported consulting health care resources compared with 45% of adults aged 25 to 44.

The survey also collected information on why people did not get help for their emotional, mental health or use of drugs or alcohol problems. The three most frequently reported

reasons were: "preferred to manage themselves", "did not get around to it/did not bother", and "afraid to ask for help or of what others would think".

Not only were utilisation rates for mental health care services low, about 21% reported unmet needs, but among those who did consult professionals, satisfaction levels were high.

The survey did not specifically address high risk populations such as First Nations but other epidemiological studies have documented high levels of mental health problems in many Canadian Aboriginal communities [8]. These studies indicate rates of psychiatric disorders varying from levels comparable to those found in the general population to up to twice those of neighbouring non-Aboriginal communities. Areas of concern include suicide, problem drinking and pervasive demoralisation.

Data from Eastern Canada, the Prairies, and British Columbia show that First Nations and Inuit people had a suicide rate in 1997 that was up to almost three times higher than the 1996 rate for the total Canadian population [9]. The 1996 crude suicide rate in Northwest Territories Inuit was about six times higher than the national rate. Young men were the most common population group to commit suicide [9]. Alcohol intoxication appeared in 33% of suicides in the Northwest Territories.

Other negative consequences of alcohol and substance abuse are also more severe in indigenous Canadians, and Aboriginal youth are at two to six times higher risk for every alcohol related problem than their non-Aboriginal counterparts in the Canadian population.[9] A report by the Canadian Centre on Substance Abuse and the Addiction Research Foundation of Ontario suggested that Aboriginal men may be more apt to abuse alcohol while women tend to abuse drugs alone [9]. In 1996, Aboriginal people 15 years of age or older living in the Northwest Territories were almost three times more likely than non-Aboriginal residents to have used marijuana or hashish in the past year and three-and-a-half times more likely to have used LSD, speed, cocaine, crack or heroin [9].

APPENDIX 3

Summary of Evidence for Activities that Promote Mental & Emotional Health

Perinatal & 0 to 2 years	Pre-school 2 to 4	Children 5 to 12	Adolescent 13 to 19	Young Adult 19 to 25	Adult 25 to 65	Senior 65+
Home visits Educational childcare Parent support Promote attachment Engaging Learning Environment	Programs that promote: self-concept, self-esteem, and coping skills Skill-based interventions which focus on specific life events Interventions for children of divorcing parents		General health promotion Programs aimed at developing self-concept Programs to develop coping skills for stressful situations Tailored interventions for bereavement etc		Mass media to improve general attitudes (most effective when complemented by focused community activities) General health promotion programs to prepare for life transitions Brief interventions for: critical illness, divorce Interventions for unemployed: social support, problem solving, cognitive-behavioural training Postnatal visits Structured groups for women Interventions for carers focusing on support or coping	Support General health

HDA: Research and Evidence: Effectiveness of mental health promotion interventions

APPENDIX 4

Situations which increase risk and for which Targeted Secondary Prevention Initiatives may be helpful

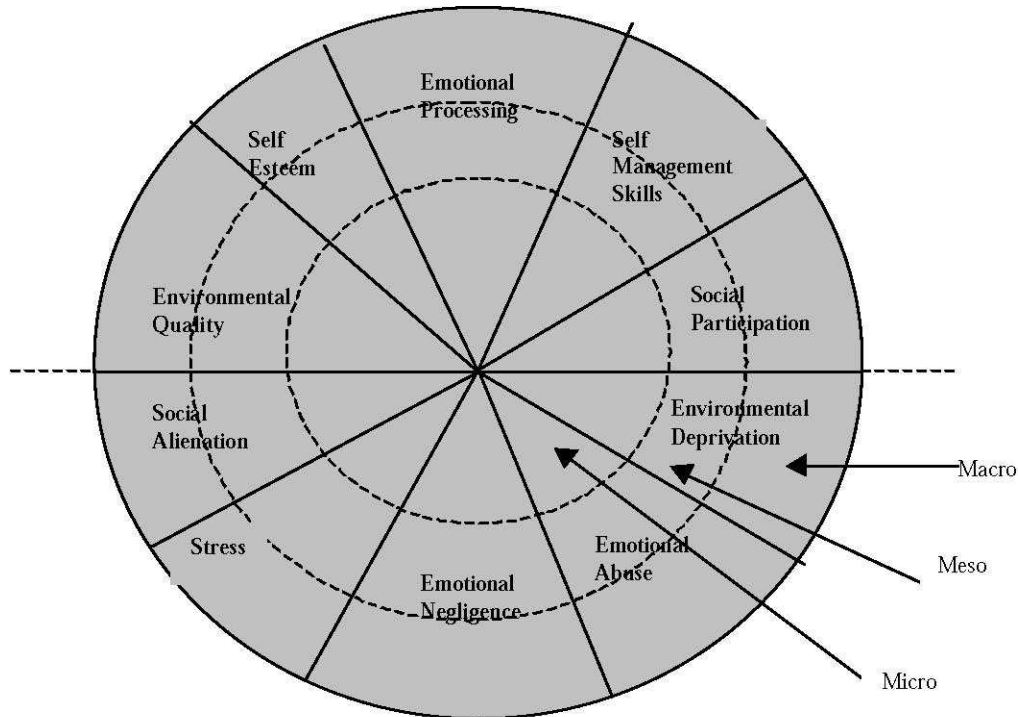
Perinatal & 0 to 2	Pre-School 2 to 4	Children 5 to 12	Adolescent 13 to 19	Young Adult 19 to 25	Adult 25 to 65	Senior 65+
Low infant birth weight	Disruptive behaviour disorders	Parental education below grade 10	Discord & family violence	Socially alienated or disadvantaged	Workplace stress	Physical impairments
Birth complication	Insecure attachment	Parental unemployment	Coercive parenting style	Unemployed	Non-meaningful work	Isolation & lack of social networks & supports
Poor infant health	Coercive parenting practices	Discord and family violence	Poor monitoring supervision home/ school	Minority citizen	Divorce	Loss of spouse
Insecure attachment	Parental depression	Coercive parenting style	Poor monitoring & supervision at home& school	Resident of rural or isolated area	Bereavement	Long term care provider
Inadequate cognitive stimulation	Anxiety & stress	Poor monitoring & supervision at home& school	Low teacher-student attachment	Teenage marriage	Substance misuse	
Abuse and neglect	Parental drug & alcohol misuse	Low teacher-student attachment	Alienation from school	Substance abuse	Family member with mental/ physical disability	
Mental or physical problems in a parent	Parental criminality or mental disorder	Poor peer relations	School dropout	Family discord, violence	Criminal activity	
Poverty	Marital discord	Inconsistent behaviour management in home / school	Experience of abuse or violence	Criminal activity	Work stress	
Developmental disorders	Economic deprivation	Alienation from school	Parental mental disorder	Body Image	University stress	
Intellectual disability	Developmental disorders	Parental criminality, substance misuse or mental disorder	Substance misuse	University stress	Social isolation	
	Intellectual disability		Criminality		Family discord, violence	
			Poor body image		Long term care provider	

Adapted from: National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000.

APPENDIX 5

Mental and Emotional Health Promotion

Figure 2: A map of positive and negative influences on Mental Health (Source: Minding our Health 1999) [2]



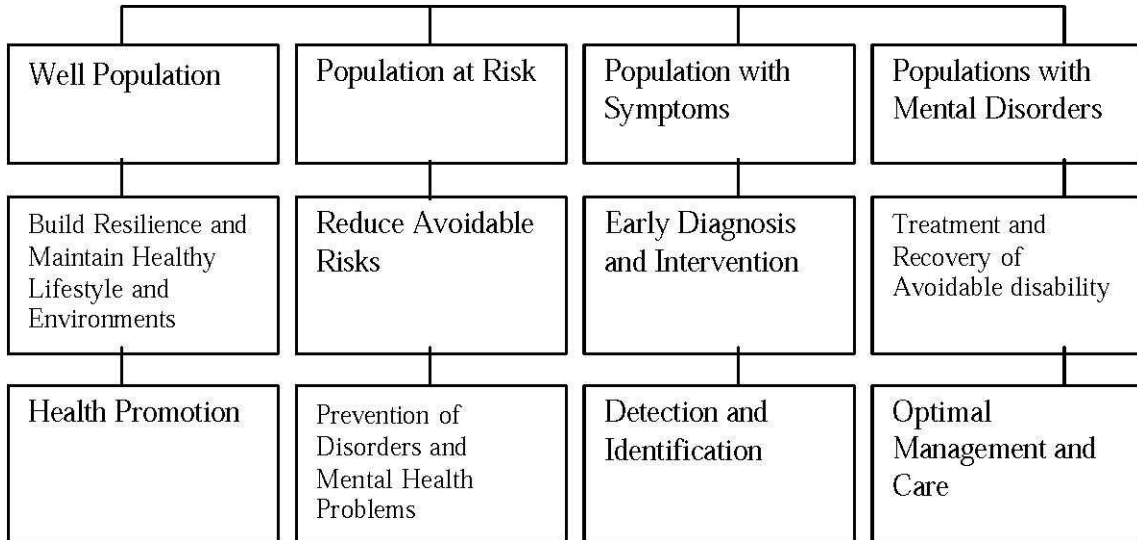
Increasing the elements above the central dotted line, or decreasing the elements below it, can promote mental health. Action can occur at a number of levels:

- Macro - local and regional policies;
- Meso - family and community needs;
- Micro - individual needs and preferences.

Further dimensions could be added to this model, such as life stages and settings, to demonstrate the range of activities and the need for intervention throughout life. Influences are wider than health services. Good housing, having a job, access to services and activities that promote health generally, as well as services directly targeted at the primary prevention of mental health problems are all able to deliver benefits for mental health.

Figure three identifies a population perspective for developing a mental health promotion framework.

Figure 3: The Health Australia discussion paper on mental health promotion (Source: Building capacity to promote the mental health of Australians 1996) [15]



APPENDIX 6

Mental Health Promotion Activities

The working group was influenced by work undertaken in Northern Ireland that stressed that any strategy and action plan should address issues which affect mental health; it should have a mental health rather than a mental illness focus and should aim to cover the needs of individuals and communities, not just those with existing mental health problems. It should also aim to increase understanding about mental health, develop education programmes and plan a media strategy to support the framework.

The strategy and action plan focuses on the differing needs of children, young people, adults and the elderly and identify groups, within each of these age ranges, which might benefit from specific intervention to promote good mental health and well being.

It specifically addresses suicide and deliberate self-harm particularly among young people and include measures to help young people develop a positive self-image and healthy and satisfying relationships with peers and family.

In summary mental health promotion may involve a number of different activities:

- increasing awareness and understanding of mental health issues in the community;
- enhancing positive mental health in the community;
- targeting vulnerable groups who are at risk;
- ensuring that those with existing mental health problems maximise their chance of full and lasting recovery;
- ensuring that those with continuing mental health problems experience as little stigma and exclusion from opportunities available to others in the community.

The home, schools, workplace, community, health and social services, and the media are all settings where specific population groups can be reached and specific mental health issues can be addressed. We therefore support a multi-sectoral approach, supported by a strong policy context.

In childhood the importance of promoting mental health through the family, through childcare services, through social services departments, and through out of school activities as well as through schools is emphasised. For adolescents voluntary, community and youth settings as well as training and post-secondary education join schools, family and statutory services as arenas for action. For adults this spectrum of collaboration extends to include the workplace or further education and relevant statutory, voluntary and community organisations with which they come into contact. An employer's duty of care under health and safety, employment and civil law extends to the mental well being of employees. Employment laws such

as equal opportunities, fair employment, disability discrimination and race relations also address the legal responsibilities of employers towards employees who may be mentally ill.

Many voluntary and community organisations contribute to improving the health of those in need, whether that need arises from social disadvantage, or physical or psychological problems. In addition, many voluntary organisations are concerned with suicide e.g. Help lines, or are focused on helping those with a greater risk of suicide e.g. The Canadian Mental Health Association. Many of these organisations are involved in the training of personnel from other voluntary and statutory services. Their role should be recognised in funding arrangements with the statutory sector.

Knowledge of all services offered by the voluntary and community sector for coordinated and effective working in a geographic location may not be apparent to statutory services and vice versa for the support of the distressed and the disadvantaged.

The media also have a role to play. There is widespread lack of understanding and awareness of how to look after mental health, how to recognise and act on early signs of mental distress, when to seek help and what type of help may be available.

Children and young people

Since childhood mental distress is strongly predictive of poor mental health and social outcomes in adult life, preventive interventions for children may bring long-term psychological, social and economic benefits [16].

Poverty: Socially disadvantaged children are at higher risk of mental health problems and later life. A number of interventions have been shown to be effective in disadvantaged communities

- High quality preschool and nursery education can produce improved self-esteem, motivation, social behaviour and other educational and social outcomes.
- Social support visits to provide new parents with child-rearing skills are effective. Parent training is likely to be adequate when parental skills deficits are accompanied by a combination of health and socio-economic problems. A trial of support by mature 'lay' mothers showed improvements in maternal mental health and childcare [19]. Support during pregnancy is discussed later.

Substance and alcohol use: Most studies are school-based, though some also involved parent and community involvement [10]. Although school-based health education programmes are effective in increasing children's knowledge of health topics, they do not produce lasting behavioural change [10]. There is insufficient evidence from these studies to assess the impact of parent and community involvement. There is some evidence that school-based interventions for substance abuse have some effect in changing knowledge about drugs and alcohol. More innovative programmes might bring about significant

changes in health behaviour, but it is difficult to quantify the impact of the interventions from the existing literature. Innovative health promotion interventions include the following: social skills and resistance skills training; the exploration of influences and pressures children feel; activities aimed at building self-esteem and self-awareness; activities aimed at building awareness of social norms and establishing group norms; and activities involving the use of peer leaders. These interventions share much common ground with many mental health promotion interventions and the health promoting school initiative of the World Health Organisation.

Behavioural difficulties: Childhood behaviours such as expressed aggression and mood changes are part of ordinary day-to-day behaviour [16]. However, when these are sufficient to cause distress, they are sometimes considered to constitute disordered behaviour. Diagnostic labels are not particularly helpful in this context and studies measure a variety of outcomes such as aggressive behaviour, social acceptance, low self-esteem and anxiety. Since childhood mental health problems are strongly predictive of poor mental health and social outcomes later in life, prevention may bring long-term psychiatric, social and economic benefits [20, 21].

Various studies have explored the effectiveness of training parents to develop the skills necessary to deal effectively with childhood behavioural problems. (Table 1) [16] Interventions involving parental role playing, behavioural management and play skills reduced attention deficit and hyperactivity symptoms, as rated by teachers and parents [22] Similarly, a trial in Ireland found that parent training resulted in improved behaviour and psychological symptoms in children and increased parental self-confidence [23].

A two-year programme, which included family management training for parents and social skills training for their seven-year-old boys who were assessed as disruptive by teachers, was highly effective in reducing behavioural and adjustment problems, after a further 3 years of follow up [24]. Individual home-based training of parents in social learning techniques may be as effective as office-based individual and group training and also cheaper [25]. This suggests that parent training programmes such as self-administered video-tape training, which are shown to be cost-effective at improving parent-child interactions and conduct disorders in children referred for treatment, can also be useful as preventive interventions [26-28].

Two trials examined the effect of school-based social skills training on socially rejected children [29, 30]. Both showed improvements in social skills and reduced social isolation. Assertiveness training has been reported to improve behaviour in children with early behavioural problems, although this conclusion was based on non-randomised sub-group analysis and may not be reliable [31].

Teenage pupils with low self-esteem benefited from a cognitive-behavioural intervention delivered over two days by an interactive personal computer programme in a school setting [32]. This has yet to be evaluated as a health intervention. Ethnic minority teenagers with severe behaviour problems in the USA showed modest improvements in self concept and short-term reductions in anxiety following an intervention based on

social learning theory in which they were exposed to positive adult role models of the same ethnic group [33].

The Olweus study in Norway showed that both being a bully or a victim of bullying is a predictor for later problems, including conduct disorders, crime and alcohol abuse (bullies) and depression, anxiety and suicidal behaviour (victims) [34]. Significantly, Olweus did not find any correlation between low self-esteem and being a bully. Effective interventions to deal with the problem should include a systemic approach to the whole school, as well as individuals.

Violence prevention: Some early intervention programmes for conduct disorders are related to violence prevention rather than mental health. Of the eight studies reviewed by the New Zealand Clearing House for Health Outcomes and Health Technology Assessment (NZHTA), five of the interventions were in schools and three in the community [10]. The studies were predominantly school-based curriculum-driven universal interventions, directed at the general school community. Results indicated a very limited effect of these school programmes in altering outcomes such as attitudes to violence or levels of self-reported violence. However, follow-up was very short in all but one of the studies [35]. In this one, positive results were achieved after two years for only one of the three cohorts who received the intervention. Two community-based interventions for youth found generally encouraging results, though a parent-focused intervention had limited success [36].

Depression: The three studies identified by the NZHTA Report investigated mood disorder prevention in young people at high-risk for major depression through school-based interventions. The improvements, regardless of condition, in two studies might be due to a therapeutic effect of the screening interviews used to identify participants at risk for depression. However, it appears that classroom-based skills-oriented interventions may prevent depression in young people [37]. Further research is required, with larger samples and methodologically rigorous designs.

Eating Disorders: The NZHTA Report only identified four relevant studies of early interventions for restrictive eating disorders. Two focused on university undergraduates, and the other two included high school students with sub-sample analyses of women at high-risk for eating disorders. Three interventions included lesson-based group discussions, and the other intervention involved software resources and an e-mail discussion list. Overall, these studies reported limited and inconsistent levels of effectiveness for interventions involving female students in late adolescence. Body image attitudes were improved by the intervention in two studies. However, there were no effects on eating disordered behaviour. Interventions for students at high-risk for eating disorders reported mixed results. The improvement over time in two studies, regardless of condition, suggests a possible effect of altering attitudes through completing questionnaires. No impact on eating behaviour was demonstrated despite some short-term changes on intermediary variables such as self-esteem and body dissatisfaction

Children and divorce or bereavement: Children who experience serious adverse life events such as parents divorcing or the loss of a close relative may develop behavioural and emotional problems. Parental separation is more common, and its adverse effect greater than that due to parental death [38].

School-based programmes for children of divorcing parents have been shown to improve mental health. The Children of Divorce Intervention Programme (CODIP) used weekly school-based sessions, led by trained facilitators, to communicate feelings, provide emotional support and develop the skills needed to resolve interpersonal problems. Ten-year-olds showed significantly greater gains in terms of adjustment and lower anxiety than were evident within the control group immediately after the intervention [39]. In less rigorous evaluations, a similar programme in younger children within ethnic minorities also reported benefits [40, 41], but no longer-term follow-up has been reported. A more labour intensive intervention with 7 to 10-year-olds showed, after one year, that skill building improved children's adjustment to their circumstances, thereby reducing anxiety and improving their ability to deal with emotional conflict [42].

Workshops exploring issues of grief, loss and family dynamics provided for children who had experienced the death of a parent, reported improved parent-child relationships and a reduction in parental reports of depression and behaviour problems in older children after six months [43].

Adults (working age and over 65) [16]:

Undergoing divorce or separation: Separation and divorce can lead to a number of severe mental health problems. There is evidence that a mental health promotion intervention can reduce psychiatric symptoms under these circumstances both in the short term and longer term [44].

The University of Colorado Separation and Divorce Programme for newly separated people that used individual counselling and group study to provide general support and build specific coping skills, was evaluated in volunteers [45]. Reported improvements in psychological adjustment and lower levels of psychiatric symptoms were sustained over four years [46-48].

Experiencing unemployment [16]: Not all unemployed people are at equal risk of depression. Evaluation shows that effective interventions are those with a strong focus on job search self-efficacy, social and emotional coping skills and building social support. The unemployed can be helped to deal with feelings of helplessness and depression, and their chances of finding a job can be increased [49].

An evaluation of a US programme (JOBS) aimed at improving job-search and problem-solving skills and helping the recently unemployed cope with setbacks demonstrated better mental health, motivation and employment outcomes which were sustained over a 2.5 year follow-up [16]. However, a subsequent large RCT reported that the benefit was confined to people with depressive symptoms, financial strain and low assertiveness, who

were vulnerable to deterioration in mental health [50]. Cognitive behavioural therapy may increase mental health, possibly by increasing employability in longer term unemployed professionals.

Depression in pregnancy: Ten to 15 % of mothers experience postnatal depression. This can lead to chronic mental health problems and adversely affect the child [16].

Home-based social support to pregnant women at high risk, such as socially disadvantaged groups by health care professionals improves mental health outcomes for both mother and baby. Continuous support for women during labour from friends or lay volunteers, can also reduce depression and raise self-esteem [16].

The evidence for the effectiveness of interventions to specifically prevent postnatal depression is more equivocal. Antenatal and postnatal parenthood groups for high risk first-time mothers were found to result in a significant reduction in postnatal depression in the first two months [51]. However, a more recent study found no effect, possibly due to the low (30%) uptake [52]. A small trial found that a 15-minute tape recording using relaxation and guided imagery in the first 4 weeks postpartum improved psychological outcomes [53].

Women who experience a miscarriage, a perinatal death, or have a pregnancy terminated are also at increased risk of psychological morbidity, especially in the first few months. None of the three trials examining various forms of counselling or psychological debriefing showed a sustained effect [54-56].

Bereavement: Several programmes aimed at reducing mental health problems in recently bereaved spouses have been evaluated in RCTs. The Family Bereavement Programme mentioned earlier showed positive effects resulting from grief workshops for children and their parents [43]. A self-help 'Widow to Widow' programme, in which recently widowed women received support from another widow and attended small group meetings, showed accelerated achievement of landmark stages such as starting a new relationship and new activities. However, there were several weaknesses in the methods used [57].

In contrast, bereavement counselling showed no effect on quality of life, satisfaction or frustration levels of people close to deceased cancer patients [58]. A small trial of different models of nurse-led group psychotherapy failed to show any difference in depression among spouses of people who had committed suicide [59].

Long-term caregivers of people who are highly dependent: There are several evaluations of ways of improving the psychological health of those who are caring for people who are highly dependent either because of age or physical or mental ill health. Nearly all studies of caregivers report high praise for the services received, independent of changes in levels of distress. Consequently, only studies that examined measures of caregiver distress are included.

In a meta-analysis of 15 studies, over half of which were RCTs, in which caregiver

distress was measured [60], only two types of intervention were shown to be effective: individual psycho-social interventions and receipt of respite care. Group psychosocial interventions showed less effect, a finding confirmed in studies directly comparing individual and group interventions [61].

Several other experimental evaluations have been reported since this meta-analysis was published. Two trials show that interventions such as group sessions for carers, combined either with training in assertiveness and coping skills [62] or with counselling [63] can reduce psychological morbidity in those caring for older people with Alzheimer's disease, at least in the short term. In addition, a psycho-educational programme was found to increase the coping ability of adults caring for ageing parents [64].

A group intervention aimed at spouses of frail elderly veterans also found short-term improvements in coping and reduced stress [65]. Intensive support with case management and respite care was shown to reduce depression and anxiety in parents of children with handicapping conditions [66]. RCTs of counselling by itself showed no sustained effect on improving carers' mental health or reducing strain in the families of patients admitted for schizophrenia.

Teenage parents and their children:

There is a high incidence of poor outcomes among the children of teenage parents including developmental and learning problems, and child maltreatment [67]. Parenting programmes may have effective in improving outcomes for both teenage parents and their children. Both individual and group-based parenting programmes produce improvements in a range of maternal and infant measures of outcome including mother-infant interaction, language development, parental attitudes, parental knowledge, maternal mealtime communication, maternal self-confidence and maternal identity [67]. There is, however, a need for further research into the effectiveness of parenting programmes for teenage parents [67].

Summary

The scientific literature suggests that interventions that are targeted at specific high-risk groups are the most effective. This is especially the case for individuals who have multiple risk factors, such as a recent life event or pregnancy, social disadvantage and pre-existing dysphoria and low self esteem. Particular programmes for which there is greatest evidence of effectiveness include:

- school education and support visits for new parents can improve mental health in children and parents in disadvantaged communities;
- school-based interventions and parent training programmes for children showing behavioural problems can improve conduct and mental well being;
- mental health problems in children of separating parents can be reduced by providing cognitive skills training and emotional support;

- social support and problem solving or cognitive-behavioural training in the unemployed can improve mental health and employment outcomes;
- mental health problems often experienced by long-term carers can be prevented by respite care and some forms of psychosocial support.

The evidence from these effectiveness reviews should inform work to support mental and emotional health in Nova Scotia.

APPENDIX 7 - WHO and Stats Canada

The World Health Organisation estimated that 815,000 people killed themselves worldwide in 2000, giving an overall age-adjusted rate of 14.5 per 100,000. Suicide in Canada is a significant public health problem that is largely preventable [77]. Canadians are seven times more likely to die from suicide than to be the victim of a homicide. Aboriginal Canadians, especially young native males, are at high suicide risk [77]. Some aboriginal communities have rates 3-5 times higher than the general population. Suicide is currently the fifth leading cause of death among Canadians and is the second leading cause of death among Canadian children and youth aged 10 to 24 years. In 1998, approximately 3,700 Canadians took their own lives, an average of about 10 suicides per day that year [77]. There is a concern that the incidence of suicide, especially among young men may be increasing. Nova Scotia has reported slightly more than 100 deaths due to suicide per year during the past twenty years. Suicide is one of the top three injuries causing death and hospitalization in Nova Scotia [79].

Table 3: Suicides, and suicide rate, by sex, by age group

	1996	1997	1981	1991	1996	1997
	Number of suicides		Suicide rate per 100,000 population			
All ages	3,941	3,681	14.0	13.3	13.2	12.3
Males	3,093	2,914	21.3	21.6	20.8	19.6
Females	848	767	6.8	5.3	5.6	5.1
1-14 years	41	51	0.7	0.6	0.7	0.9
Males	32	39	1.0	0.7	1.1	1.4
Females	9	12	0.4	0.4	0.3	0.4
15-19 years	231	261	12.7	13.8	11.5	12.9
Males	190	207	21.2	23.0	18.5	19.9
Females	41	54	3.8	4.0	4.2	5.5
20-24 years	350	293	19.6	18.2	17.2	14.5
Males	300	257	33.2	31.7	29.0	24.9
Females	50	36	5.9	4.1	5.0	3.6
25-44 years	1,770	1,549	17.4	18.1	17.9	15.8
Males	1,390	1,228	26.2	28.8	24.7	25.0
Females	380	321	8.6	7.6	8.6	6.6
45-64 years	1,060	1,075	20.1	16.2	16.6	16.5
Males	786	826	28.6	25.7	24.7	25.5
Females	274	249	11.9	6.9	8.6	7.6
65 years and over	489	452	18.3	14.2	13.4	12.4
Males	395	357	30.4	26.3	25.6	23.0
Females	94	95	9.2	5.6	4.5	4.5

Source: Statistics Canada, Health Statistics Division.

In terms of comparisons with other Canadian provinces and other countries, the suicide rate for the Maritimes almost matched that of Canada at 12 per 100,000. (Table 4). The overall suicide rate in Canada is similar to that of the United States but considerably higher than in the United Kingdom and Australia where there have been active efforts at suicide prevention.

Comparative suicide rates per 100 000 people in 1993 and potential years of life lost (PYLL) per 1 000 people in 1993, by industrialized country and by region of Canada						
	SUICIDE RATE			PYLL		
	MEN	WOMEN	TOTAL	MEN	WOMEN	TOTAL
Québec	29.4	7.1	18.1	10.7	2.5	6.6
Australia	18.7	4.3	11.4	6.4	1.4	3.9
Austria	32.0	9.6	19.7	8.5	2.6	5.6
Belgium (1989)	27.4	10.5	18.3	7.4	2.8	5.1
Denmark	27.7	13.3	20.3	7.5	3.0	5.3
Finland	44.8	11.0	27.3	14.6	3.5	9.1
France (1992)	30.2	10.0	19.4	8.3	2.7	5.5
Germany	21.8	7.1	13.9	5.7	1.7	3.8
Hungary	56.4	15.8	34.5	14.9	3.7	9.2
Iceland	15.2	6.1	10.7	5.6	1.7	3.7
Israel (1992)	13.3	4.6	8.9	5.3	4.6	1.0
Japan	20.8	9.3	14.9	5.6	2.2	3.9
Netherlands	13.4	6.5	9.9	4.1	1.9	3.0
Norway (1993)	20.9	7.6	14.1	7.0	2.3	4.7
Spain (1992)	10.9	3.0	6.7	2.7	0.7	1.7
Sweden (1992)	20.8	8.9	14.7	5.9	2.6	4.3
United Kingdom	12.8	3.4	8.0	4.3	1.0	2.7
United States	20.8	4.7	12.3	6.6	1.5	4.0
Maritimes	20.1	4.1	12.0	*	*	*
Ontario	15.7	4.6	10.0	5.0	1.5	3.2
Prairie Provinces	23.6	5.8	14.7	*	*	*
Alberta	26.4	5.9	16.1	9.0	1.8	5.5
British Columbia	18.5	4.6	11.5	6.4	1.6	4.0
Canada	20.8	5.3	12.9	7.4	1.9	4.7

Source: World Health Organization, MSSS, Danielle Saint-Laurent, 1997.
 * Data not computed.

Table 4 [75]

Factors Associated with Suicide [10]

Three different types of people attempt suicide – those who want to die, those who want to escape mental distress in the short term and those for whom it is an appeal or an attempt to mobilise or move others [10]. It is those in the first group, who are by far the smallest group, who are most likely to commit suicide [80].

There is no single cause of suicide. It is possible though to identify factors, which may make people more vulnerable to suicide and precipitating events, which may trigger a suicidal process [10].

It is estimated that one per cent of those who make a suicide attempt die within the following year [10]. These people are more likely to be those who are of an older age group, male, separated, living alone and who have a history of psychiatric illness, a history of alcohol misuse or have physical ill-health [78].

The increasing suicide rate in those aged 15 to 24 years is associated with a number of other population characteristics; higher divorce rate, high unemployment, reduction in the population under the age of 15 years, increase in the percentage of the population over 65 years, more women in the work force and an increase in women in tertiary education. Other factors associated are an increase in alcohol consumption and a reduction in church membership [10].

A number of risk factors for suicide have been highlighted in various studies. These can be divided into primary, secondary and situational risk factors and are described next.

Primary risk factors for suicide

Mental illness

There is clear relationship between mental illness and suicide. The commonest diagnoses are depression, schizophrenia, personality disorder and alcohol or drug dependence. A quarter of suicides have been in contact with mental health services in the year before death. Half the suicides had been in contact with mental health services in the week before death. Less than half of community suicides received any form of psychological intervention, including psychological support [10].

Alcohol and drugs misuse

Substance misuse may supplement other risk factors through reduced personal control and more reckless behaviour.

Previous Attempt

Lewinsohn found that subjects who reported having made at least one suicide attempt prior to the study were nearly twenty times more likely to make another attempt than those who did not report a previous attempt [81]. They concluded that the “strongest

predictor of future attempt was the occurrence of a past attempt.

Hopelessness

A study of 14 to 20 year olds in Holland found that certain characteristics such as hopelessness and low self-esteem were predictors of suicide attempts. Adolescents with eating disorders were also at increased risk [82].

Follow-up of a group of adolescent psychiatric patients over a 10-year period demonstrated that more than 90% of the eventual suicides were predicted by the degree of hopelessness and pessimism that they expressed [83].

Secondary Risk Factors for Suicide

Personality disorder [10]

Independent risk factors for suicide include personality disorder particularly antisocial avoidant and dependent disorders [84, 85]. Adolescents who have been diagnosed with a personality disorder may be up to 10 times more likely to attempt or commit suicide than those who have not [86]. Although personality disorder and conduct disorders are significant risk factors in themselves, they are particularly predictive of suicide attempts especially in combination with substance abuse and depression [87].

Physical illness

Chronic physical disorders are known to be common among suicide victims. This is particularly true for elderly male victims. The link between suicide and physical illness may be due to several factors including pain, depression, alcohol abuse and difficulty in coming to terms with the illness [87].

Situational Risk Factors

Family environment

Some family characteristics have been identified as common factors in adolescent suicides. These are a family history of mental or emotional distress, a family history of suicidal behaviour, family breakdown and childhood neglect or abuse [88-89].

Social relationships

Being recently bereaved is a suicide risk factor. Parental death during childhood may increase the subsequent risk of suicide in adulthood and recent bereavement is also an associated factor [90]. Peer relationships are also important in adolescence and the break up of a sexual relationship, particularly in young males, appears to be a substantial risk factor. With both bereavement and relationship breakdown, the individuals most at risk of suicide are those who have a previous history of suicidal behaviour. Social isolation, being unmarried and living alone are more common in those with depression who later commit suicide than those who do not. Some elderly persons who have committed suicide had had little social contact, for instance they had only been visited once a month or less [91]. This was in comparison to controls who were repeatedly visited more than

once per week and had less emotional distress.

Unemployment

While there is a known association between unemployment and suicide, especially in men, the nature of this link is not clear [92]. It may either reflect the effect of unemployment on mental health or the increased risk that people with psychiatric disorders have of being unemployed.

Media coverage

Exposure to suicide in the media may be a risk factor for adolescents who may imitate the act. There has been an increase in adolescent suicidal deaths during a 1 to 2 week period following media coverage of a prominent suicide or after fictional television shows featuring adolescent suicide [10].

High risk groups

From the risk factors described in the previous sections, we can identify several groups who are at particularly high risk and should be particularly targeted [75]:

- Men at risk of suicide
 - with problems of substance abuse or dependency (drugs, alcohol or other);
 - young people with mental disorders;
 - in prison
- Men presenting a number of risk factors.
- People at risk of attempting suicide or who have already attempted suicide
- Young women between the ages of 14 and 19 presenting a number of risk factors;

APPENDIX 8

Recommended Components for a Suicide Prevention Strategy for Inclusion in the Mental Health Prevention, Promotion and Advocacy Strategy for Nova Scotia

Submitted for Consideration by the Nova Scotia
Community Network to Address Suicide
(NSCNAS),
February 18, 2004

A. Introduction

The NSCNAS was formed to fulfil the priorities of the first Suicide Symposium, which was held in May 2003 at Mount St Vincent University, Halifax, NS. The well-attended symposium was a clear demonstration by community groups, individuals and government of the need for action on this serious issue. The NSCNAS now welcomes the opportunity to frame a suicide prevention strategy for Nova Scotians.

The *Suicide Prevention Strategy* section of the draft document entitled *Mental Health Promotion, Prevention and Advocacy Strategy for Nova Scotians* deals with the specific issue of suicide. However, there is recognition by NSCNAS that many of the contributing risk factors for suicide overlap with the determinants and circumstances of general mental and emotional well being. The summary points and recommended actions contained in this draft complement those put forward in other sections of the PPA draft, and are found in a number of national and provincial strategies reviewed by NSCNAS.

When the term “*suicide prevention strategy*” is used in this document, it is understood by the authors to include prevention, intervention and postvention.

B. Definitions¹

To ensure a common understanding of the terminology used in this paper, the following well-used terms are defined for the readers:

- 1. Suicidality:** A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.
- 2. Suicidal Ideation:** Self-reported thoughts of engaging in suicide related behavior.

¹*American National Strategy for Suicide Prevention*, United States Department of Health and Human Services, 2001.

3. Suicidal Behaviour: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

4. Suicidal Act (also referred to as suicide attempt): A potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

5. Suicide: Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act lead to the person's death.

6. Self Harm/Self Injury: The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Table: Health Canada Statistics from PPA document.

C. Context and Rationale

Suicide in Nova Scotia is a significant public health problem, and is both an individual /family and community tragedy. There were approximately 3700 deaths due to suicide reported in Canada in 1998². Nova Scotia reported slightly more than 100 deaths due to suicide per year during the past twenty years. (**need source- PPA document*). As well, suicide is one of the top three injuries causing death and hospitalisation in Nova Scotia.³

Suicide prevention is a complex issue that requires a multi-faceted approach to develop a comprehensive, provincial strategy. To be comprehensive the strategy will need to encompass prevention, intervention and postvention, and include multi-sectoral involvements looking at all the determinants of health in addition to immediate risk factors.⁴ The following statement describes how suicide prevention efforts are done most effectively:

“Suicide prevention efforts will be ineffective if they are not set within a framework of large scale plans developed by multi disciplinary teams comprising government officials, health care planners and health care workers, and researchers and practitioners from a variety of disciplines and sectors. Major planning and resources and collaboration between these groups will go a long way towards reducing this important health problem”.⁵

² Guo, B., Ann Scott, Samantha Bowker, *Suicide Prevention Strategies: Evidence from Systematic Reviews*, February 2003, page 1.

³Presentation entitled Comprehensive Report on Injuries in Nova Scotia, by S Ackroyd and JM Tallon.

⁴ Report on Proposed National Priorities for Injury Prevention and Control, by the Federal Provincial Territorial Sub Committee on Injury Prevention and Control , December 2001.

⁵ World Health Organization, *World Report on Violence and Health*. Krug, EG, Dahlberg, LL, Mercy, JA, Zwi, AB, Lozano, R editors. Geneva, Switzerland” World Health Organization, 2002, p 206.

In addition, the development of resilience and protective factors by individuals and communities is crucial to a comprehensive plan. These factors may include methods that address well being and generic skill building such as developing strong social, problem solving and coping skills, and having supportive relationships.⁶

D. Recommended Components of a Suicide Prevention Strategy

The NSCNAS reviewed and analysed existing strategies to prepare the following list of recommendations for inclusion in a provincial prevention strategy. In addition to being crucial to a comprehensive strategy, the following components are the most amenable to evaluation.

1. Provide a Provincial Network of Comprehensive, Integrated Services

The following components are included:

- Prevention: “suicide prevention includes any self-injury prevention or health promotion strategy generally or specifically aimed at reducing the incidence and prevalence of suicidal behaviours (i.e. reducing risk)”.⁷
- Intervention: “suicide intervention includes early recognition and assessment of risk, immediate response, resource referrals, and follow-up management and treatment of individuals at risk of suicide”⁸.
- Postvention: “refers to the general care and support or special treatment needed by survivors of a suicide”.⁹ A general discussion was held during the May/03 Suicide Symposium, and the direction taken to include activities undertaken to deal with the aftermath of suicide when referring to postvention.

Recommendations:

- conduct a comprehensive province-wide needs assessment;
- identify services currently available;
- determine those services that are working well;
- then, identify gaps in service provision and identify what services are needed.

⁶ Draft Document, Unpublished Report entitled *Benchmark Report: The Status of Suicide in Nova Scotia*, 1st Suicide Symposium Report, by Susan Hare, Maeve MacDougall and Sandra Nicholas, 2003.

⁷ *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada*, Health Programs and Services Branch, Health Canada, 1994, page 57

⁸ Ibid, page 57

⁹ Ibid, page 57

- Complete a comprehensive search of evidence-based best practices for suicide prevention.
- Develop an implementation plan for province-wide services.

2. Improve Skills of Professionals, Gate Keepers and Lay Persons

Improved training and skill building for all key players was identified during a focus group at the 2003 NS Suicide Symposium as a top priority for attention in a NS Suicide Prevention Strategy. In addition, the Mental Health Standards of the Department of Health identify suicide risk assessment as a core competency for mental health staff¹⁰

Recommendations:

- Develop standards for basic suicide risk assessment and intervention for persons working in all service areas identified in #1, and for specialized training for mental health care staff.
- Explore and develop training packages for both basic and for specialized training.
- Develop an implementation plan for province-wide training.

3. Reduce Availability and Lethality of Suicide Methods

Removing access to means of suicide has been identified in the literature as crucial to a comprehensive suicide prevention strategy. Research indicates that limiting access to lethal means such as firearms, and limiting the package sizes for medications such as aspirin, reduced mortality.¹¹

Recommendations:

- Identify the lethal methods most common in NS.
- Develop policies limiting access to those methods.
- Promote initiatives designed to restrict access to, or minimize risks of, those methods.

4. Conduct Research on Suicide and Suicide Prevention

Useful and timely local and national research on suicide-related topics is currently limited. In order to understand the complexities of suicide, and then develop effective suicide prevention initiatives, enhanced research is required. Nova Scotia has the capacity to develop partnerships and initiate opportunities for ongoing research on suicide.

¹⁰ Standards for Mental Health Services in Nova Scotia, Department of Health, 2003, page2.4

¹¹ *World Report on Violence and Health*, WHO, 2002

Recommendations:

- Promote and adequately resource research on suicide prevention, intervention and postvention.
- Research needs to be connected to accurate surveillance measures in NS.
- Local research needs to be linked to other provincial, national and international research.
- Identify priority areas of research including assessment of screening tools to identify risk factors for suicide.

5. Evaluation

Evaluation needs to be built into the design of the strategy; there is a need to determine the impact of suicide prevention activities on suicide and attempted suicide rates. As well, there is recognition that suicide rates should not be the only measure for the effectiveness of programs, a point well expressed by the following:

“Suicide is an outcome of complex interactions among neurobiological, genetic, psychological, social, cultural and environmental risk and protective factors...determining the effects of suicide prevention strategies is a difficult task.”¹²

It is imperative to include implementation indicators, which measure the effectiveness of prevention activities and monitor outcomes. To ensure inclusiveness, evaluation needs to be long term, multifaceted, include both deaths and attempts, and be based on accurate surveillance. Tools to measure outcomes such as HoNOS, can be used to measure overall outcomes.

Recommendations:

- Identify gaps and weaknesses in current surveillance activities in NS.
- Develop a body to initiate, co-ordinate and support evaluation & research.
- Designate this body to share knowledge and findings to the field.

6. Roles and Responsibilities

Those working in suicide prevention at the local, regional and provincial levels need to know their respective roles in dealing with this issue. An enhanced sense of joint responsibility needs to be fostered amongst the partners, which include representation from communities, service providers, and government.

¹² *Suicide Prevention Strategies: Evidence from a Systematic Review*, Bing et al, Feb 2003

Recommendations:

- Identify the key players.
- Appoint a provincial coordinator/lead agency to work with the key players to describe the roles and responsibilities of each in implementing the suicide prevention strategy in an inclusive and multi-sectoral process.

7. Investment of Solutions

To implement a suicide prevention strategy there will need to be adequate resources to ensure positive outcomes. This fact is stated clearly in the following:

“Major planning, resources and collaboration will go a long way to reducing this important public health problem.”¹³

Recommendations:

- Identify resource needs for formal as well as community & informal support services.
- Facilitate distribution of resources for suicide prevention services.
- Ensure that suicide prevention receives an equitable share of financial resources allocated for health programs with similar impact (i.e. those preventing death).

8. Reduce Risk and Improve Resiliency and Protective Factors in Key High Risk Groups

Through a review of existing suicide prevention strategies from other provinces & countries, there are focused interventions for high-risk groups. These groups vary according to geographic location, cultural issues and societal events. There may be special groups in NS for which focused intervention is required.

Recommendations:

- Identify high-risk groups in NS.
- Research and explore potential for focused interventions.

9. Youth

“Suicide closely follows motor vehicle collisions as the most likely cause of death among Canadian Youth ages 10-24 and results in one of the highest rates of potential years of life lost”.¹⁴ Of particular concern is the high incidence in young men, particularly of

¹³ *World Report on Violence and Health*, p206)

¹⁴ *Report on Proposed National Priorities for Injury Prevention and Control*, Federal/Provincial/Territorial Sub Committee on Injury Prevention and Control, Dec 2001.

aboriginal origin¹⁵. By developing resiliency and protective factors in youth, the plan is to reduce the incidence of suicide in this group. As such, this group has been identified as a separate component of the prevention strategy.

Recommendations:

- Identify key players working with youth and collaboratively develop guidelines.
- Develop focused strategies targeting their special needs, which address help seeking behaviours, anti-stigma/attitudes, and generic skill building.

10. Public Awareness

Accurate media portrayal of suicide and improved public awareness of the issues are crucial to the success of a province-wide suicide prevention program. One way to enhance reporting in the media is the development of guidelines for responsible reporting to the public of the complexities of suicide. The portrayal should include information on the early recognition of mental health problems and guidance on how to seek appropriate help. There is a need to connect with the Anti Stigma Task Group as they are working on this issue.

Recommendations:

- Develop a communication plan for portrayal of suicidal behaviour, mental illness and addictions in the media in NS.
- Develop an information package on the implementation of the Suicide Prevention Strategy.
- Ensure the dissemination of accurate information on suicide by linking with credible sources.

E. Conclusions

A comprehensive Suicide Prevention Strategy demonstrates the commitment of key players to reduce the incidence of suicide in the province, and to ensure Nova Scotians have access to needed services when experiencing suicidal behaviours. As a voice of community groups, first voice and government, NSCNAS is pleased to contribute meaningfully to the *Mental Health Promotion, Prevention and Advocacy Strategy for Nova Scotia*.

¹⁵ Guo et al, page 1.

APPENDIX 9

Characteristics of People at High Risk

Some characteristics of people at high risk

Children who are:

- living in poverty;
- exhibiting behavioural difficulties;
- experiencing parental separation or divorce;
- within families experiencing bereavement.

Adults who are:

- undergoing divorce or separation;
- unemployed;
- at risk of depression in pregnancy;
- experiencing bereavement long term caregivers of people who are highly dependent.

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